FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING INITIATIVES IN KAKAMEGA EAST SUB COUNTY, KAKAMEGA COUNTY.

BY

ODUK PETER OMOGI

A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN PROJECT PLANNING AND MANAGEMENT OF THE UNIVERSITY OF NAIROBI

2015
DECLARATION

This research project report is my original work and has not been presented for any award in any University.

Sign:.................... Date:....................

Oduk Peter Omogi
L50/69531/2013

This research project report has been submitted for examination with our approval as the University supervisors:

Sign:.................... Date:....................

Dr. Nyonje Raphael Ondeko
Lecturer, Department of Extra-mural Studies
University of Nairobi

Sign:.................... Date:....................

Prof. Rambo Charles M.
Lecturer, Department of Extra-mural Studies
University of Nairobi
DEDICATION

To my beloved wife Tabitha, my children Martin and Anne, my parents John and Leonida Oduk and my Sponsor Santiago Perez, Charles and Hellen Oketch dear friends Paul Omondi and Phabian Agiso.
ACKNOWLEDGEMENTS

Foremost, I would like to acknowledge my supervisors, Dr. Raphael Nyonje and Prof. Rambo Charles M. for the invaluable comments, assistance and advice they offered to me during the formulation and accomplishment of this study. Their scholarly guidance, insights, constructive comments, critiques, selfless devotion and critical revision of the drafts made it possible for me to complete this research project.

My sincere gratitude also goes to Dr. Okello, Dr. Joseph Awino and Dr. Jabuya for their critique, comments and advice on the study.

I also acknowledge the University of Nairobi for giving me a conducive learning environment and their library staff including Mr. S. Matanda, Mr. T Atieno, Miss. Miriam Masinde and Mr. N. Genga for their valued assistance in finding library information for formulating and conducting this study. I also feel indebted to the Kenya National Bureau of Statistics (KNBS), Kakamega and Kisumu offices for allowing me to access and use the demographic data for formulating and conducting the study. I also want to acknowledge my research assistants namely Mary Sari, Eric Shinali, Aggry Nakhali and Peninah Ayoti who assisted me in data collection and entry as well as the study respondents for accepting to participate in the study. Special acknowledgment also goes to Christine Adhiambo for the editing, formatting and printing services she offered on the research documents. Finally I would like to thank everyone who in one way or another contributed in the carrying out of this research project.
TABLE OF CONTENT

DECLARATION .............................................................................................................. i
DEDICATION ............................................................................................................... ii
ACKNOWLEDGEMENTS .......................................................................................... iii
TABLE OF CONTENT .............................................................................................. iv
LIST OF FIGURES .................................................................................................. viii
LIST OF ABBREVIATIONS AND ACRONYMS ......................................................... x
ABSTRACT ............................................................................................................. xi

CHAPTER ONE ........................................................................................................ 1
INTRODUCTION ....................................................................................................... 1
1.1 Background of the Study .................................................................................. 1
1.2 Statement of the Problem ............................................................................... 6
1.3 Purpose of the Study ....................................................................................... 7
1.4 Objectives of the Study .................................................................................. 7
1.5 Research Questions ........................................................................................ 8
1.6 Significance of the study ............................................................................... 8
1.7 Basic Assumptions .......................................................................................... 9
1.8 Limitations of the study ................................................................................ 9
1.9 Delimitations of the study ............................................................................. 10
1.10 Definition of Significant Terms .................................................................... 10
1.11 Organization of the Study ............................................................................ 11

CHAPTER TWO ....................................................................................................... 12
LITERATURE REVIEW ............................................................................................ 12
2.1 Introduction ..................................................................................................... 12
2.2: The Concepts of Male Involvement in Family Planning Initiatives .................. 12
2.3 Social Factors Influencing Male Involvement in Family Planning initiatives ......... 13
   2.3.1 Influence of Gender Roles on Male Involvement in Family Planning Initiatives
       ................................................................................................................................ 13
   2.3.2 Influence of Religion on Male Involvement in Family Planning Initiatives .... 15
2.3.3 Influence of Spousal Communication on Male Involvement in Family Planning Initiatives ................................................................. 17
2.3.4 Influence of Knowledge of Contraception on Male Involvement in Family Planning Initiatives ............................................................... 18

2.4 Strategic Factors Influencing Male Involvement in Family Planning ................................................................. 19
  2.4.1 Influence of Method of Family Planning On Male Involvement in Family Planning Initiatives ............................................................... 20
  2.4.2 Influence of Projects Design on Male Involvement in Family Planning Initiatives ................................................................. 21

2.5 Economic Factors Influencing Male Involvement in Family Planning Initiatives ...... 23
  2.5.1 Influence of Income on Male Involvement in Family Planning Initiatives ...... 23
  2.5.2 Influence of Unmet need on Male Involvement in Family Planning Initiatives 24

2.6 Cultural Factors Influencing Male Involvement in Family Planning Initiatives ...... 25
  2.6.1 Influence of Perception on Male Involvement in Family Planning initiatives .. 26
  2.6.2 Influence of Fertility Preference on Male Involvement in Family Planning initiatives ................................................................. 27

2.7 Theoretical Framework ......................................................................................................................................................... 28
2.8 Conceptual Framework ......................................................................................................................................................... 29
2.9 Knowledge Gap ........................................................................................................................................................................... 31
2.10 Summary of Literature Review .................................................................................................................................................. 31

CHAPTER THREE ................................................................................................................................................................................. 32

RESEARCH METHODOLOGY ............................................................................................................................................................... 32

3.1 Introduction ..................................................................................................................................................................................... 32
3.2 Research Design ............................................................................................................................................................................. 32
3.3 Target Population ............................................................................................................................................................................ 33
3.4 Sample Size and Sampling Procedure ........................................................................................................................................ 33
  3.4.1 Sample Size ............................................................................................................................................................................. 33
  3.4.2 Sample Selection Procedure .................................................................................................................................................... 34
3.5 Data Collection Instruments .......................................................................................................................................................... 34
  3.5.2 Pre-testing ................................................................................................................................................................................ 35
  3.5.3 Validity of the Instruments ....................................................................................................................................................... 36
  3.5.4 Reliability of the Instruments .................................................................................................................................................. 36
3.6 Data Collection Procedure ............................................................................................................................................................ 37
CHAPTER FOUR  

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSIONS  

4.1 Introduction ........................................................................................................ 39
4.2 Questionnaire Return Rate .............................................................................. 39
4.3 Demographic characteristics of respondents ................................................ 39
  4.3.1 Distribution of Respondents by Age .............................................................. 40
  4.3.2 Distribution of Respondents by Marital Status ............................................. 40
  4.3.3 Distribution of Respondents by Level of Education ..................................... 41
  4.3.4 Distribution of Respondents by Monthly Income ........................................ 42
  4.3.5 Distribution of Respondents by Religious Affiliation .................................. 43
4.4 Influence of social factors on male involvement in family planning initiatives .... 44
  4.4.1 Influence of Gender Roles on Male Involvement in Family Planning Initiatives  .................................................................................................................. 44
  4.4.2 Influence of Religion on Male Involvement in Family Planning Initiatives .... 47
  4.4.3 Influence of Spousal Communication on Male Involvement in Family Planning Initiatives .......................................................... 48
  4.4.4 Influence of Knowledge of FP on Male Involvement in Family Planning Initiatives .................................................................................................................. 50
4.5 Influence of Strategic Factors on Male Involvement in Family Planning Initiatives .................................................................................................................. 53
  4.5.1 Influence of family planning method on male involvement in family planning initiatives .................................................................................................................. 53
  4.5.2 Influence of Project Design on Male Involvement in Family Planning Initiatives .................................................................................................................. 55
4.6 Influence of economic factors on male involvement in family planning initiatives .... 57
  4.6.1 Influence of income on male involvement in family planning initiatives ....... 57
  4.6.2 Influence of unmet need for family planning on male involvement in family planning initiatives .................................................................................................................. 59
4.7 Influence of cultural factors on male involvement in family planning initiatives ...... 60
  4.7.1 Influence of perception on male involvement in family planning initiatives .... 60
4.7.2 Influence of fertility preferences on male involvement in family planning initiatives .................................................................61

CHAPTER FIVE .................................................................................64

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS ......64

5.1 Introduction ..............................................................................64
5.2 Summary of Finding ..................................................................64
5.3 Conclusions .............................................................................68
5.4 Contribution to the Body of Knowledge ....................................70
5.5 Recommendations ....................................................................71
5.6 Suggestions for Further Research .............................................72

REFERENCES ..................................................................................73

APPENDICES ..................................................................................81

APPENDIX 1: HOUSEHOLD AND POPULATION DATA .......................81
APPENDIX 2: QUESTIONNAIRE FOR STUDY RESPONDENTS ..........82
APPENDIX 3: RESEARCH PERMIT .....................................................85
APPENDIX 4: MAP OF STUDY SITE ...............................................86
LIST OF FIGURES

Fig. 2.1: Conceptual Framework ........................................................................29
LIST OF TABLES

Table 4.1: Distribution of Respondents by Age ................................................................. 40
Table 4.2: Distribution of Respondents by Marital Status. ............................................. 41
Table 4.3: Distribution of Respondents by Level of Education ........................................ 42
Table 4.4: Distribution of Monthly Income of Respondents .......................................... 43
Table 4.5: Religious Affiliations of Respondents................................................................. 44
Table 4.6: Male Concern with FP issues ......................................................................... 45
Table 4.7: Decision making on FP ................................................................................. 46
Table 4.8: discussion of family planning with partner ...................................................... 48
Table 4.9: Influence of Spousal Communication on Male Involvement in Family Planning. ......................................................................................................................... 49
Table 4.10: FP methods known by respondents. .............................................................. 50
Table 4.11: Opinion of respondents on the Influence of FP Knowledge on Male Involvement in Family Planning Initiatives. ................................................................. 52
Table 4.12: Modern Family Planning used in the last 6 months. ..................................... 53
Table 4.13: Reasons for not consider undergoing Vasectomy. .......................................... 54
Table 4.14: Involvement in design of FP Initiatives ......................................................... 55
Table 4.15: Ability to purchase condom for every protected sex intercourse ................. 57
Table 4.16: Choices to use when respondent can’t afford condoms. ............................. 58
Table 4.17: Access to family planning methods ............................................................... 59
Table 4.18: Perception on Male Involvement in FP initiatives ........................................ 60
Table 4.19: Fertility Preferences ...................................................................................... 62
Table 4.20: Use of FP for limiting and spacing ............................................................... 63
Table 5.1: Study Contribution to the Body of Knowledge .............................................. 70
LIST OF ABBREVIATIONS AND ACRONYMS

CPR  Contraceptive Prevalence Rate
DHHS  Department of Health and Human Services
FP  Family Planning
HIV  Human Immunodeficiency Virus
ICPD  International Conference on Population and Development
IEC  Information, Education and Communication
IMNCS  Improving Maternal, Neonatal and Child Survival.
IPPF  International Planned Parenthood Federation
KDHS  Kenya Demographic and Health Survey
KNBS  Kenya National Bureau Of Statistics
MAP  Men As Partners
MDGs  Millennium Development Goals
MMPP  Male Motivation and Planned Parenthood
NCPD  National Commission on Population and Development
OPAC  Office of Population Affairs Clearinghouse
PPAG  Planned Parenthood Association of Ghana
PPASA  Planned Parenthood Association of South Africa
TFR  Total Fertility Rate
UNFPA  United Nations Population Fund
USA  United States of America
ABSTRACT

The purpose of this study was to investigate factors influencing male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County. The specific objectives of the study included; establishing the extent to which social factors influence male involvement in family planning initiatives in Kakamega East Sub County; determining the extent to which strategic factors influence male involvement in family planning initiatives in Kakamega East Sub County, assessing the extent to which economic factors influence male involvement in family planning initiatives in Kakamega East Sub County and examining the extent to which cultural factors influence male involvement in family planning initiatives in Kakamega East Sub County. Literature giving the global, regional and local perspectives on the study objectives was extensively reviewed by the researcher to give a fuller understanding of the issues as well as the present situation on the subject matter of the study for comparison purposes. The study was premised on the social cognitive theory and adopted descriptive survey design to target men aged 18-55 years spread across the study area. Simple-random sampling technique was used to sample 395 male household heads from a population of 29,128 households to participate in the study. Data for the study was collected through questionnaires and was organized and presented using frequency tables. Validity for the tools was achieved by subjecting the tools to the review of university supervisors and peers. The researcher was assisted by trained research assistants in administering the questionnaires. The study found out that social factors such as religion, knowledge on FP, gender roles and spousal communication influenced male involvement in family planning. From the study 66.7% of the respondents were of the opinion that men should be involved in family planning with 69.7% indicating that their religion was against the practice of family planning. Over sixty six percent (66.1%) of the respondents approved of family planning as personal decision. The study also found that 50.7% of the respondents had never been involved in any project design activities, thus were locked out from involvement. In addition FP methods are some of the strategic factors that influence male involvement in family planning with 83.9% saying they would not go for vasectomy and that they were limited to only male condom. The study also established that economic factors such as income and unmet need for FP also influenced male involvement in FP. The study also found that fertility preferences and perception are some of the cultural factors that influence male involvement in family planning. For instance, the study found that 72.2% of the respondents preferred more than 3 children, thus have lower demand for FP for limiting as well as spacing. The study therefore recommended that projects that focus on public awareness and service provision on FP be initiated by different stakeholders to address the existing knowledge and service delivery
gaps. Further, the study recommended that project designers should involvement in the life cycle of FP projects to achieve sustainable results. The study suggested that a similar study be conducted in other parts of the county to enable a formulation of male involvement in FP policy and program in the county.
CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Access to safe, voluntary family planning (FP) is a human right. FP is central to gender and women’s empowerment and it is a key factor in reducing poverty. Yet some 225 million women globally who want to use safe and effective FP methods are unable to do so because they lack, among others support of their partners or communities (UNFPA, 2014).

Historically, however, most family planning programs and projects offered their services exclusively to women. Most viewed women as the "target group" and paid little attention to the roles that men might have with respect to women's reproductive health decision-making and behavior (Shahjahan et al, 2013). Sternberg & Hubley (2004) points out that during the 1980s many health promoters implemented sexual and reproductive health programs designed to empower women and protect them from the impact of men's behavior. Mehta (2002) reports, however, that a few programs made attempts to address men's needs for information and services, with these efforts mainly focused on encouraging men to use family planning methods (such as condoms and vasectomy) or to become more active in the couple's decision-making about contraceptive use.

There is consensus that male-involvement in family planning not only helps in accepting a contraceptive, but also in its effective use and continuation. On the other hand, even if the wife wants to use contraceptive, she may not be able to use it or may be forced to discontinue the method, if the husband disapproves of contraception (Green, 2000a; Khan & Patel, 1997; UNFPA, 1995).
Since the Cairo’s initiative about two decades ago, a lot of attention has been directed towards increasing men’s involvement in family planning services in many countries. In the 1990s, many women's health programs began to acknowledge that family planning must be viewed in the broader context of reproductive health. As part of this broader view, programs started to focus on the role of men as it relates to women's access to and use of reproductive health services. The 1994 International Conference on Population and Development (ICPD) in Cairo Program of Action emphasizes the need to promote active involvement of men in family planning (ICPD, 1994).

According to the Office of Population Affairs Clearing House (OPAC, 2008), USA, reproductive health research on men is considerably less developed than comparable research on women. As a result, men receive considerably fewer reproductive health services than women. In 2002, only 30% of men aged 20–44 received a reproductive health service—defined as birth control (including condom) advice or services; STI advice, counseling, testing or treatment; HIV advice, counseling or testing; or advice about sterilization (OPAC, 2008). Through its ‘Title X Project’, USA implemented under the Medicaid program has taken initiative in more than half the state to expand the program’s role by extending coverage for family planning to women and men not otherwise covered by Medicaid (DHHS, 2008). This project involves men in family planning to achieve maximum success and sustainability of family planning initiatives.

In India, Khan & Patel, (1997) reports that the study of male's role in family planning is still a neglected area. The writers contend that contraceptive use pattern has undergone major changes during the last 30 years. According to them, in the 1960s and 1970s, males were the main acceptors of family planning (vasectomy and condom) and their proportion was always more than 50 per cent of the total family planning acceptors. Khan and Patel
hasten to point out that with the introduction of new technology such as laparoscopic sterilization, the family planning program orientation slowly shifted towards women.

In Bangladesh family planning program services are not utilized properly because all kinds of projects, activities and policies were being focused mainly for women (Clark, Yount & Roger, 2008). Clark, Yount & Roger (2008) also point out that most of the family planning field service delivery system is female based and field workers are also females, who mainly target the women because of convenience. According to Hossain (2003), this practice gives very little opportunity for men to receive service from family planning providers as well as get actively involved in family planning initiatives. According to Nasreen et al. (2012), men who were involved with ‘Improving Maternal, Neonatal and Child Survival’ (IMNCS) program were more likely to support their partners in regards to reproductive health issues compared with those not involved in this project. In this project, men were included in the family planning trainings and activities. They were also encouraged to accompany their partners to FP sessions and each female accompanied by the male partner were served right away without having to queue. These greatly encouraged their involvement.

Similarly, Wang et al. (1996) found lower contraception discontinuation rates in their randomized study in China: when both partners were educated about family planning, IUD users had significantly lower pregnancy and abortion rates than users whose husbands were not educated with their wives on the matter.

In 1987, Ghana's Health Education Sub County of Ministry of Health began a systematic family-planning IEC project that aimed at increasing knowledge; improving attitudes toward family planning as well promote contraceptive use among men and women of reproductive (Kim et al. 1992). Through its Male Motivation and Planned Parenthood (MMPP) project in 1980, the Planned Parenthood Association of Ghana
(PPAG) sponsored three pilot "Daddies Clubs" which in 1982 recruited 5000 acceptors, a majority of whom were encouraged by men participation in the MMPP project (IPPF, 1982).

In South Africa Men as Partners (MAP) program developed in 1998 as collaboration between EngenderHealth and Planned Parenthood Association of South Africa (PPASA), works with men to promote gender equity in order to foster the sexual and reproductive health of both women and men (Peacock, 2002). This has been spurred by the recognition that men's attitudes and behaviors can either impede or promote sexual and reproductive health. The MAP program undertakes initiatives that encourage positive male involvement in family planning.

In a study conducted in Malawi, Soldan (2004) concludes that men dominate decision-making regarding family size and their partner's use of contraceptive methods in many traditionally patriarchal settings. Men in Sub-Saharan Africa are often the primary decision-makers about family size and use of family planning (Nzioka, 2001; Soldan, 2004; Oyediran, and Isiugo-Abanihe, 2002).

Kenya was one of the first African countries to recognize the importance of Family Planning (FP) as a core element in economic and social development (Ajayi & Kevole, 1998). As early as 1957, the Pathfinder Fund assisted the Family Planning Committees of Mombasa and Nairobi to open FP clinics, which went on to become the Family Health Options Kenya. The country has a high Total Fertility Rate (TFR) at 4.6, with rural and urban areas recording 5.2 and 2.9 respectively ((KNBS, 2010). Despite overall use of modern contraceptive use increasing steadily from 6% in 1978 to 53.6% in 2009, use of male condoms still remains low at 15.2% (KNBS, 2010:60). Facing an annual population growth rate of 2.9 percent (KNBS, 2010), the Government of Kenya incorporated FP into the country's overall development policy in 1965, and by the mid-1980s, the growth rate
began to decline. The Sessional Paper No.3 of 2012 on Population Policy for National Development (NCPD, 2012) for instance recognizes the critical role men play in a couple’s uptake of contraception and recommends the promotion of male involvement in family planning. Therefore, it is geared towards further reducing fertility through the improved provision of family planning which promotes male involvement.

Kakamega County is ranked second after Nairobi County in terms of the population size, with the population standing at 1,660,651, a population growth rate of 2.5 % and a fertility rate of 5.6 % which is 1% higher than the national fertility rate of 4.6 % (KNBS, 2010). With this population size and Total Fertility Rate (TFR), Kakamega County is envisaged to be experiencing immense challenges related to population dynamics. Ngetich (2013) argues that with this statistics, family planning programmes needs to be intensified in order to reduce the rapid population growth. The Kakamega county strategic plan recognizes the existence of unequal participation by men and women in the population and development process (KNBS, 2005). Among its strategic output targets include enhanced provision and quality of family planning services and facilities and integrating population issues into development.

According to the 2009 national census on population, Kakamega East Sub County had a total population of 137,800 people (KNBS, 2010). The county is focusing on managing population growth to facilitate sustainable development in the division. A report by the Kenya Alliance for Rural Empowerment (KARE), a local NGO based in Shinyalu reveals that involving men in family planning can greatly improve success and impact of such initiatives (KARE, 2012). This assertion is supported by other researches which suggest that male involvement can increase uptake and continuation of family planning methods by improving spousal communication through pathways of increased knowledge and reduced opposition (Kabagenyi et al, 2014; Hartmann et al, 2012; Sternberg, 2004).
1.2 Statement of the Problem

The fertility rate in Kakamega East Sub County has continued to grow. Standing at 5.6 %, and a population of 137,800 (KNBS, 2010), this fertility rate possess major challenges to the population as it creates intense completion for resources. Ngetich (2013) argues that with this statistics, family planning programmes needs to be intensified in order to reduce the rapid population growth. Despite the Kakamega county strategic plan recognizing the existence of unequal participation by men and women in the population and development process (KNBS, 2005), there is no initiative in the Sub County to involve men in family planning or empirical information to help in designing initiatives that can make this a reality. Despite research indicating that population control and management be an all inclusive affair, the projects, programs and activities being undertaken by both public and private institutions in the area with regards to family planning have largely excluded men.

Knowledge on family planning among men stand at 27% compared to 69% among women in western Kenya (Onyango, Owoko & Oguttu, 2010). This suggests that family planning initiatives have not targeted men in education and awareness creation. A baseline study conducted by Kenya Alliance for Rural Empowerment (KARE), a local NGO based in Shinyalu reveals, that only 21% of men were involved in family planning initiatives and only 34% of men approves of their partners using contraceptives.

Even though there are numerous studies emphasizing the benefits of involving men in the success of reproductive health and family planning programs (Dewi, 2009; Kabagenyi et al, 2014; Hartmann et al, 2012; Sternberg, 2004), limited studies have been conducted regarding the specific factors that influence men’s involvement in family planning initiatives in western Kenya, especially Shinyalu. Onyango, Owoko & Oguttu (2010), argue that there is a dearth of literature on factors which influence male involvement in
reproductive health from the perspective of men themselves. A pilot project by the organization dubbed ‘Men Allied for Health and Non-Violence’ (MAHN) has shown several challenges associated with male involvement in family planning. The pilot was largely unsuccessful based on the poor availability of information in best practices on involving men in FP initiatives.

To address this gap, this study examined the factors that influence male involvement in family planning in Kakamega East Sub County, Kakamega County, Kenya with a view of highlighting its implications for future design, planning, implementation, evaluation and research of family planning and reproductive health projects.

1.3 Purpose of the Study

The purpose of this study was to investigate factors that influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County.

1.4 Objectives of the Study

The study was guided by the following objectives:

1. To establish the extent to which social factors influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County.
2. To determine the extent to which strategic factors influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County.
3. To assess the extent to which economic factors influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County.
4. To examine the extent to which cultural factors influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County.
1.5 Research Questions

1. To what extent do social factors influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County?

2. To what extent do strategic factors influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County?

3. To what extent do economic factors influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County?

4. To what extent do cultural factors influence male involvement in family planning initiatives in Kakamega East Sub County, Kakamega County?

1.6 Significance of the study

The study was deemed important because the findings could be used by both the national and county governments as a basis of formulating policies that relate to family planning and reproductive health. Development experts, organizations and institutions especially those concerned with the implementation of vision 2030, Millennium Development Goals (MDGs) and other development blueprints in the sector of family planning and women empowerment would also find the results of the study useful in both review of the existing projects as well as designing, planning, implementing and evaluating future projects. The study will also be of great importance to other researchers and academicians who seek to understand the factors that influence men’s involvement in family planning and how these factors can be mainstreamed into the project cycle for achieve lasting impact. In addition, the community including households and families could also use the findings of the study to challenge themselves and to adopt practices that can help them in family planning. Finally, besides being a requirement for the fulfillment of my award for the degree of Master of Arts in Project Planning and...
Management of the University of Nairobi, the study is very useful as it will enable me to deepen my understanding of the various factors that influence male involvement in family planning and enable me to plan and manage family planning related projects more effectively and efficiently.

1.7 Basic Assumptions

The researcher assumed that the respondents would provide honest and truthful information regarding the study leading to results that could be generalized to the population. It was also assumed that respondents will be willing to participate in the survey by agreeing to respond to the questionnaires. The researcher assumed that sampling men alone in the study will give valuable information for the scope of the study. Further, it was assumed that absence of respondents due to short term variation would not affect the generalization of research findings to the population. The researcher assumed that if various factors influencing male involvement in family planning initiatives are addressed, then various stakeholders will meet the target of family planning in line with vision 2030 and constitution.

1.8 Limitations of the study

The study focused on knowledge, perceptions, practice, attitudes on FP which are personal and sensitive. Therefore, some respondents may not have been willing to provide all the information required by the researchers because of the fear of being judged. Efforts were however made to reduce this problem by assuring the respondents of the confidentiality of all information provided. In addition, most of the roads in Kakamega East Sub County are not tarmacked thus are difficult to use especially during the rainy seasons. The researcher countered this limitation by using motorbikes that were able to
access many parts of the Sub County and also used the services of locals who understood the short-cut access (panya) routes.

1.9 Delimitations of the study

The study was conducted in Kakamega East Sub County in Kakamega County. Kakamega East Sub County was chosen since it is one of the rural sub-counties with the highest fertility rate and population density in Kakamega country. Since the study was about understanding the factors that influence male involvement in family planning initiatives the target population of the study were male household heads.

Since the study was a social science research and the target population had varied socio-economic status and varied demographic characteristics, the study was restricted to descriptive survey design. The chosen design was deemed appropriate for the collection of information on perceptions, attitudes, experiences and behavior of respondents that can be generalized to the entire population.

The instrument for collecting data was also restricted to questionnaires.

1.10 Definition of Significant Terms

**Cultural factors** Are the established norms, beliefs, values and traditions held by the study population including perception and fertility preferences.

**Economic factors** These are factors connected with the economy and helps to facilitate or impede access to Family planning services, items and products and include unmet needs for FP and income.

**Factors** These are main issues that have influence on male involvement in family planning and include strategic, social, economic and cultural factors.
Influencing The effect that the social, strategic, economic and cultural factors have on male involvement in family planning.

Male Involvement in Family Planning Initiatives- all activities, projects and programs geared at ensuring active participation and shared responsibility between both partners in family planning matters, with the aim of ensuring joint decision making on contraceptive use.

Social factors These are factors that are brought about as a result of the interactions and relationships in the society and include religion, gender roles, spousal communication and knowledge.

Strategic factors These are factors related to how the FP initiatives are delivered to the target populations and include FP methods and FP project design approaches.

1.11 Organization of the Study

The study was organized in five chapters. Chapter one constituted the background of the study, statement of the problem, purpose of the study, research objectives, research questions, significance of the study, limitations of the study, delimitations of the study and the basic assumptions of the study. Chapter two was made up of the literature review on the objectives of the study that explored the global, regional and local literature. It also included the theoretical and conceptual framework of the study as well as brief descriptions of the concept of male involvement in family planning. Chapter three was the research methodology which contained research design, study population, sample and sampling technique, instrumentation, validity and reliability of the research instruments, data collection procedure and data analysis procedure. Chapter four contained the analyses, interpretation and discussion of data while chapter five contained the summary of the findings, conclusions and recommendations.
CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviewed literature related to the study based on the thematic areas covered within the formulated objectives of the study. The section begins with a description of the concept of male involvement in family planning. Substantial literature is reviewed on the strategic, social, cultural, and economic factors influencing male involvement in family planning initiatives. The section also discussed the theoretical and conceptual framework underpinning the study and the relationship between the variables influencing male involvement in family planning initiatives.

2.2: The Concepts of Male Involvement in Family Planning Initiatives

Since the Cairo’s initiative about two decades ago, a lot of attention has been directed towards increasing male involvement in family planning services. However, there has been no generally accepted understanding of what male involvement in family planning means. Toure (1996) defined male involvement as all activities targeted at increasing the number of men who use contraceptives. Greene (2000) criticizes Toure’s definition by defining male involvement as all organizational activities targeted at men with the objective of increasing the number of men that encourage and inspire their wives to use family planning services, as well as influence the policy environment making it conducive for male-related programmes and not just increasing the number of men who use contraceptives. Furthermore according to the Cairo Action Plan, male involvement in family planning is defined as all activities that promote men’s active participation in family planning activities, projects and programs services with the aim of achieving gender equality and empowering women (UNFPA, 1995). Although the definitions above
attempt to highlight what male involvement in family planning initiatives entails, the definition by Mburu and Adams (2004) suffices in this study. According to these scholars, male involvement entails all activities geared at ensuring active participation and shared responsibility between both partners in family planning matters, with the aim of ensuring joint decision making on contraceptive use.

2.3 Social Factors Influencing Male Involvement in Family Planning initiatives

The study sought to establish the relationship between various social factors and male involvement in family planning initiatives in Kakamega East Sub-County. In this study social factors are these factors that are brought about as a result of the interactions and relationships in the society. In this study, the social factors influencing male involvement in family planning considered in this study included gender roles, religion, spousal communication and knowledge.

2.3.1 Influence of Gender Roles on Male Involvement in Family Planning Initiatives

The World Health Organization defines gender as the result of socially constructed ideas about the behavior, actions, activities, attributes and roles that a given society considers appropriate for women and women (WHO, 2009).

According to Levy (2008), a woman’s ability to control her own fertility is strongly affected by social constructs of gender roles and expectations. Researchers contend that gender inequality may determine who has access to family planning information, who holds the power to negotiate contraceptive use or to withhold sex, who decides on family size, and who controls the economic resources to obtain family planning related health services (Boender et al., 2004; FHI, 2005). These hurdles vary
from culture to culture, yet they exist throughout the world and can often lead to negative family planning health outcomes.

Data suggests that in cultures where men have ultimate authority (patriarchy), their perceived loss of control may result in verbal and physical abuse of women (FHI, 2005; Oni and McCarthy, 1991; Forest, 1984; Speizer et al., 2005; Adongo, et al., 1997). Family Health International’s Women’s Studies Project surveyed participants in Bolivia and the Philippines about their experiences with gender and family planning. The research found that women’s use of contraception, possibly indicative of increased autonomy and men’s loss of control, was a factor in domestic violence. Of the male participants in the study, 100% reported that they had either physically or verbally abused their partners, and half reported being physically violent. Similarly, 25% of women surveyed in the Philippines said that their husbands had physically abused them (FHI, 2005).

A study conducted by Char (2011) in India confirms that, in a male dominated society, the acceptance of female sterilization based on husband’s decision alone is significant.

In one often documented mass-media campaign in Zimbabwe, well-known sports figures and traditional masculine images were used to involve men in family planning and promote use of long-term contraceptives (Mahmood and Ringheim, 1997). Although contraception use increased as desired, research later showed that the campaign goal of encouraging positive male involvement was unexpectedly met by an increase in the proportion of men who felt that they alone should be responsible for making decisions about family planning (Sinding, 2000; Boender et al., 2004). Boender et al., 2004, explains that involving men in fertility regulation may, in fact, take away the woman’s
ability to make decisions. Thus making programs, projects and activities to be gender exploitative.

In a study conducted in Malawi, Soldan (2004) concludes that men dominate decision-making regarding family size and their partner’s use of contraceptive methods in many traditionally patriarchal settings. Women point to their male partner’s resistance to family planning as a significant barrier to uptake and continuation, resulting in decisions to use contraceptive methods covertly or not at all (Biddlecom & Fapohunda, 1998). Fear of spousal retaliation due to disagreements about whether to use contraception has also been shown to be a significant barrier among women (Mundigo, 1998). This seemingly contradictory role among men of being both key decision makers regarding fertility desires and remaining detached from reproductive health issues has posed considerable challenges in African contexts to involve men to address low contraceptive prevalence rates.

According to the Kenya Demographic and Health Survey 2008-09, 16% of men believe that contraception is a women’s business and a man should not have to worry about it (KNBS, 2010).

2.3.2 Influence of Religion on Male Involvement in Family Planning Initiatives.

Religion prescribes ethical guidelines for many aspects of daily life and also navigates belief systems and norms surrounding sexuality. Religion is considered a powerful tool in swaying people’s opinion about family planning. There are religions and denominations that explicitly teach against use of family planning especially the modern contraception. Within Catholicism, for instance, the primary purpose of marriage and sexual intercourse is procreation (Schenker, 2000). Every act of intercourse must remain open to conception (Schenker, 2000). Contraception destroys any potential to produce new life and violates
the principal purpose of marriage (Schenker and Rabenou, 1993). This contraception ban is against unnatural means of contraception, which include chemical and barrier methods. Abstinence and the rhythm method are the only officially approved methods of birth spacing. This religious teaching that discourages the use of modern methods of contraception, therefore limits the choices men have as far as use of contraceptives is concerned.

Among Muslims, the majority of Islamic jurists indicate that family planning is not forbidden (Omran, 1992). Muslim opinion regarding the further classification of contraception ranges from permissible to disapproved (Omran, 1992). Some fundamentalist Muslims insist that any form of contraception violates God’s intentions (Poston L. Islam. In: Manning C, Zuckerman P, eds., 2005). Historically, however, coitus interruptus has been permitted in the Quran (Poston et al, 2005). When contraception justification is provided, such as health, social, or economic indications, coitus interruptus becomes recommended. Through analogous reasoning, authorities permit modern methods of contraception as lawful, given that they are temporary, safe, and legal (Schenker and Rabenou, 1993). Any device that does not induce abortion and is reversible may be used. Irreversible sterilization methods are not permitted (Hasna, 2003). This practice therefore leaves male Muslims with only male condoms as the only option for contraception. Contraception may be used only within marriage (Pennachio, 2005).

In Uganda, community mobilization in family planning programs has also been difficult and has been hindered by opposition to family planning on the part of some religious and community leaders (Sileo, 2014).

According to Esipisu (1992), religion is a powerful force which sways people’s opinions on the adoption of family planning. In his study in Lurambi constituency, he
noted that some religions explicitly advocate for the adoption of family planning while others oppose the practice.

### 2.3.3 Influence of Spousal Communication on Male Involvement in Family Planning Initiatives

A study conducted in Central Terai in Nepal concluded that women who discuss family planning with their husbands (OR = 7.254), perceive husband approval on family planning (OR = 5.558) and have born a son (OR = 2.239) are more likely to use a modern contraceptive method. Even though these results do not explain the direction of causality, it is clear that spousal discussion and partner approval are significant in a woman's decision to use modern contraceptives in the Central Terai region of Nepal (Yue, et al., 2010).

In a study conducted by Antenane in Ethiopia, spousal communication is reported to be an important precursor to the adoption of family planning methods. According to the study, 7% of women who had never discussed family planning with their husband use a method of contraception compared to 27% of women who discuss family planning once or twice and 40 percent of women who discuss family planning more often (Antenane, 2002).

A number of studies have documented that a deficiency on spousal communication on fertility and family planning is one of the reasons for the slow use of contraceptive methods to slow or delay childbearing (Mian et al., 2014). African countries have the lowest contraceptive prevalence rates in the world. Many researchers suggest that in addition to spousal discussion, the husband’s approval is an important predictor of accepting and using family planning methods. A husband’s opposition to family planning may prevent women from using contraception, even when the women want to prevent or delay childbearing.
Lasee and Becker (1997), for example, used the 1989 Kenya Demographic and Health Survey to find a statistically significant, positive correlation between husband and wife communication about family planning and contraceptive use, even after controlling for background factors which may have been confounding. Likewise, Bawah (2002) ran both cross-sectional and longitudinal analyses to find the same causal pathway in her Navrongo study. Oni and McCarthy (1991) also reported a positive correlation between communication and contraception use in their survey data from Nigeria. Roudi and Ashford (1996) quoted in Bawah (2002) graphically illustrated the association between couples’ communication and contraceptive use in four African countries.

2.3.4 Influence of Knowledge of Contraception on Male Involvement in Family Planning Initiatives.

Knowledge on contraception is an important determinant of male involvement in family planning and reproductive health. The result of a study conducted in Bangladesh shows that male involvement in family planning and reproductive health is higher at 78.8% among the respondents who have high knowledge on contraception and STDs while male involvement in family planning and reproductive health is lower at 39.8% among those who do not have adequate knowledge on contraception (Kamal et al., 2013).

A study conducted among tribal married men in Thane district of Maharashtra, India proved that majority of them had no concept of family spacing, those who were aware of contraceptive methods had a little knowledge of their correct use. However, 53.75 per cent had a positive attitude and 66.2 per cent wanted to know more about contraceptives, preferably through sources such as radio, television, door-to-door campaign and interpersonal communications (Ganatra, Goyaji & Rao, 1998).

According to a study conducted in 1991 by the Ghana’s Male Motivator Project (GMMP), a significant increase in men's family planning knowledge and practice, and
improvement in attitude with the increasing length of the project. Also, among those men exposed to the intensive campaign, 47% had discussed family planning with their partners, and 26% stated that they or their partners were using a more modern contraceptive method (Wegner et al., 1998).

Oni and McCarthy (1991) opine that men may only be versed in the general concept of fertility regulation, instead of having detailed knowledge of specific contraceptive methods (Oni & McCarthy, 1991). They contend that as family planning programs and services become more focused on involving the male population, men gain knowledge about family planning and become more likely to have positive attitudes regarding contraception and therefore support their partners’ use of family planning methods (Oni & McCarthy, 1991). Moreover, literature suggests that accurate knowledge is positively associated with increased contraceptive use and intentions (e.g., Alvarez et al., 2010; Credé et al., 2012; Duong, Lee, & Binns, 2005; Okech, Wawire, & Mburu, 2011). However, research in Uganda and elsewhere has demonstrated low use of contraceptives among populations with high knowledge, indicating that knowledge alone doesn’t necessarily translate to use (Chipeta, Chimwaza, & Kalilani-Phiri, 2010).

2.4 Strategic Factors Influencing Male Involvement in Family Planning

The strategic factors are those factors related to how the FP initiatives are delivered to the target populations. In this study, the strategic factors influencing male involvement in family planning initiatives considered were the FP methods and projects design approaches.
2.4.1 Influence of Method of Family Planning On Male Involvement in Family Planning Initiatives.

Generally, contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57% in 2012. In Asia, modern contraceptive use between 2008 and 2012 has remained at 62%, while in Latin America and the Caribbean it rose slightly from 64% to 67%, whereas in Africa it went from 23% to 24%, between the same period (UNFPA, 2014).

Use of contraception by men makes up a relatively small subset of the above prevalence rates. The modern contraceptive methods for men are limited to male condoms and sterilization (vasectomy). Since men have only these two modern contraceptive methods, one is forced to choose from either of the two or avoid the use altogether or rely on the traditional or natural methods.

For instance, a study conducted in Bangladesh showed that the male method contraceptive use was decreasing over time in Bangladesh, for example condom use was decreasing 14.6% to 8.21% and vasectomy use was decreasing 10.4 % to 3% from 1975 to 1993. The study revealed that men feel embarrassment to buy condom. They also faced problem of storage because they wanted to keep the condoms in hidden places where other members or children couldn’t find. Men also complained that condom smell is uncomfortable and burst out. Moreover, men reported that condom might reduce pleasure of sexual intercourse (Kamal et al. 2013). These factors influence acceptability and continuation of condoms by men as was confirmed by a study conducted by Onyango et al (2010) in their study in western Kenya.

The 2003 demographic health survey reports that even though, there has been exposure to messages about condoms, mainly through the radio in western Province; there is still low
use of condoms (0.3%) for this region (KNBS, 2004). On the other hand, male sterilization or vasectomy, which is a surgical process of cutting and tying the vas deferens in order to prevent spermatozoa from mixing with semen has been adopted by a significantly few men globally and especially in Africa. However, data on the incidence of vasectomy are difficult to obtain, as vasectomy is neither widely available nor commonly used in any countries (EngenderHealth, 2002).

According to Engender health (2014), nearly 43 million men globally use vasectomy as a method of contraception. Of the world’s total number of sterilization users, China and India account for 75% while Africa and Middle East account for lowest users. Since the procedure is irreversible, can only be done by a trained health provider and is costly the incidence or prevalence of vasectomy in still remain considerably low among men in Kenya. According to the KDHS of 1998, vasectomy prevalence stood at below 0.4% compared to a 18% in New Zealand percent in Puerto Rico and 16.2% in Canada. Even though, this method is offered free of charge at some health care centres, the prevalence still remain absolutely low A study conducted by KMET in 2009 revealed that men did not want to undergo vasectomy because they believed that it would make them unable to have sex, hence harming their standing in the society as well as cause their spouses to look for other partners (UNFPA, 2009).

2.4.2 Influence of Projects Design on Male Involvement in Family Planning Initiatives.

For projects to succeed, they must be designed in such a way as to target specific beneficiaries. Traditionally, family planning programs and projects have designed to target women since FP has been seen as feminine ideal (UNAIDS, 1999). Many program and project designers have neglected the needs of men when designing their initiatives. Since Cairo, a number of organizations and governments have been re-orienting and
enlarging their programs to include both men and women. However, one major problem with the task of reorientation is that research and programs in family planning have traditionally been focusing on women ignoring the important role of men (Becker S., 1996).

In India, Khan & Patel, (1997) reports that the study of male's role in family planning is still a neglected area. According to them, even though in the 1960s and 1970s, males were the main acceptors of family planning, prevalence being over 50%, the orientation shifted slowly from men to women especially with the introduction of new technology such as laparoscopic sterilization.

In Bangladesh family planning program services are not utilized properly because all kinds of projects, activities and policies were being focused mainly for women (Clark, Yount & Roger, 2008). Clark, Yount & Roger (2008) also point out that most of the family planning field service delivery system is female based and field workers are also females, who mainly target the women because of convenience. According to Hossain (2003), this practice gives very little opportunity for male to receive service from family planning providers as well as get actively involved in family planning initiatives.

In China, Wang et al. (1996) similarly found lower contraception discontinuation rates in their randomized study in China: when both partners were educated about family planning, IUD users had significantly lower pregnancy and abortion rates than users whose husbands were not educated with their wives on the matter.

In 1987, Ghana's Health Ministry of Health began a systematic family-planning IEC project that aimed at increasing knowledge; improving attitudes toward family planning as well promote contraceptive use among men and women of reproductive (Kim et al. 1992).
In South Africa Men as Partners (MAP) program developed in 1998, works with men to promote gender equity in order to foster the sexual and reproductive health of both women and men (Peacock, 2002). This has been spurred by the recognition that men's attitudes and behaviors can either impede or promote sexual and reproductive health.

In Kenya, the Sessional Paper No.3 of 2012 on Population Policy for National Development (NCPD, 2012) recognizes the critical role men play in a couple’s uptake of contraception and recommends the promotion of male involvement in family planning. Therefore, it is geared towards further reducing fertility through the improved provision of family planning which promotes male involvement. In their studies carried out in western Kenya, Onyango et al (2010) concludes that the traditional approaches used to design, plan and implement family planning services have a key role in influencing male involvement in family planning.

2.5 Economic Factors Influencing Male Involvement in Family Planning Initiatives

In this study, economic factors are the factors connected with the economy and works to facilitate or impede access to Family planning services, items and products. The economic factors influencing male involvement in family planning initiatives in Kakamega East Sub-County considered in this study include income and unmet needs.

2.5.1 Influence of Income on Male Involvement in Family Planning Initiatives

Income is an important factor to male involvement in family planning. In his study in India, Balaiah et al. (2005), states that men who had high income (Rs, 5000+), were 1.256 times likely to use contraceptive.

Kamal et al. (2013) also notes that couple’s income is also associated with male involvement in family planning and reproductive health. In their study in Narsingdi municipality in Bangladesh, they found that about 45.4% of males whose income is less
than 10,000 taka, 65.3% with an income between 10,000 to 20,000 and 78.7% with an income of more than 20,000 taka per month are involved in family planning and reproductive health. It is observed that male involvement in family planning and reproductive health is proportionally higher among couples with higher income compared with whose that had lower income. The Chi-square test of the study also shows the association between couples income and male involvement in family planning and reproductive health is strongly significant.

According to the KHDS (2010), contraceptive use among men increased with income. For example, 57% percent of men in the upper wealth quintile were using contraceptive while only 20% of men in the lower wealth quintile were using contraceptives.

2.5.2 Influence of Unmet need on Male Involvement in Family Planning Initiatives

According to Sonfield (2006), unmet need refers to the discrepancy between an individual’s expressed fertility desires and contraceptive practice. This definition is supported by Ross and Winfrey 2002 and Becker 1999.

Men with unmet needs for FP are broadly defined as those who want their wives to delay or limit fertility but are not using any contraception (Casterline and Sinding, 2000). Men have a crucial role in controlling fertility and influencing contraceptive use and effectiveness. Westoff and Bankole (2002) estimated that if all those with unmet need in developing countries were able to space or limit their births as desired, the total fertility rate would decline 10-25%, with the value in these ranges depending on the country, and would move 30-50% of the way toward replacement fertility. Yet in practice, the unmet needs of men have been largely ignored by family planning initiatives.

According to Jacobstein and Pile (2007), almost three-fourths of the 37 million couples who use vasectomy live in Asia, with China and India alone accounting for more
than two-thirds of this total. Four and a half million men in the developing world outside these two countries use vasectomy. Vasectomy use in Latin America has increased four-fold in the past ten years. While prevalence remains less than 1% in the most of the region, vasectomy rates in almost all of Africa are 0.1% or less, despite the fact that vasectomy services have already been introduced in some of Sub-Saharan African countries such as Ghana, Kenya, Malawi and Tanzania (Jacobstein & Pile, 2007).

Using 2007 Zambia Demographic and Health Survey, the researcher estimated that for married men, the level of unmet need for spacing, limiting and total was 28.0%, 19.5% and 47.5%, respectively. This high level of unmet need for men in the country greatly affects male involvement in FP and shows that family planning initiatives are not meeting men’s demand for family planning (Becker S.1999).

Kenyan men continue to experience a high unmet need for family planning, yet the three consecutive KDHS surveys since 1998 have never considered the men’s unmet need for family planning. Using this definition, the level of unmet need among husbands was 24% in Ghana and 23% in Kenya in 1993, whereas among wives it was 27% and 33%, respectively. Considering individual couples, fewer than half of the husbands of women with unmet need (39% in Ghana and 44% in Kenya) also had unmet need (Ngom P., 1997).

2.6 Cultural Factors Influencing Male Involvement in Family Planning Initiatives.

In this study, cultural factors are those factors related to established norms, beliefs, values and traditions held by the study population including perception and fertility preferences. In this study, the parameters factors influencing male involvement in family planning initiatives considered in this study were perception and fertility preference.
2.6.1 Influence of Perception on Male Involvement in Family Planning initiatives

Research has shown that perception and attitude can greatly influence male involvement in family planning in many societies. A study conducted by Rao and Sinha (2001) in Madhya Pradesh, India revealed that there is a strong notion in villages among both men and women that persons engaged in manual labour, such as, farmers and labourers should not go for sterilization and that, there was a fear of men losing their virility after the operation. These results reiterate the need to educate couples with complete information about each method. These results are confirmed by Okwor and Olaseha (2010) in their study in Nigeria from which they conclude that the majority of the respondents were unanimous that allowing a woman to use modern contraceptives gives room for infidelity on the part of the woman.

A study conducted by Kabagenyi et al. (2014) in Uganda indicates that a commonly reported disincentive among men to support their partner’s use of contraceptive methods related to perceived side effects which were blamed for reducing sexual pleasure and increasing women’s risks of infertility and illness. According to the study, men reported being frustrated by several observed side effects, most notably irregular and prolonged bleeding, as well as vaginal dryness, and decreases in sex drive or libido. Excessive bleeding in particular was seen as having detrimental effects on marriages as long periods of blood loss reportedly led to women’s general fatigue and dampened their interests in sexual intercourse. Bleeding was also attributed to limiting the number of opportunities for men to have sex with their partner, thus a precursor and motivation for developing extramarital sexual relations.

A study conducted by Kisumu Medical Trust (KMET) in conjunction with Boston University in Nyanza and Western Kenya revealed that the overriding factors are widespread attitudes and misconceptions about family planning for women and men
make adoption, acceptance and continuation of family planning. A majority of the male respondents in the study indicated that family planning made a woman cold in bed, while many others elicited fears that vasectomy would render them unable to have sex (UNFPA, 2009).

2.6.2 Influence of Fertility Preference on Male Involvement in Family Planning initiatives

Men’s fertility intention is closely related to adopt couples contraceptive method. In Bangladesh, Hossain (2003) found that husband’s preference for more additional children were decreasing the probability to use family planning method. Nganga (2009) points out that men have a strong desire for large families and a prevalence of many sons, who are regarded as their heirs. This thought is supported by Wambui (2012), in her study in western Kenya, in which she points out that the Luhya community still considers that children translate into wealth. The more children you have, the wealthier you are.

In Kenya, one of the challenges in the realization of the policy objective of reducing TFR from the current level of 4.6 to 2.6 children per woman by 2030. This is because the demand for children is still high and is unlikely to change unless substantial changes in desired family sizes are achieved among the poor in general, notably in the northern arid and semi-arid areas of the country. From men’s point of view, large family size gives an assurance of economic rewards, respect and security for old age (Mburugu & Adams, 2004).

According to the KDHS (2008-9), fertility preferences are closely related to the number of living children a person already has. About three in four married men without a child want to have a child soon. This proportion declines dramatically as men have more children, so that among women with five or more children, only 4% want to have another one soon. Similarly, only 3% of childless men say they don’t want to have a child
at all. However, men show greater interest in controlling the pace of child bearing once they have a child (KNBS, 2010).

2.7 Theoretical Framework

This study was informed by Bandura’s social cognitive theory in an attempt to explain the factors influencing male involvement in family planning. Social cognitive theory propounded by Bandura, posits that the process through which people learn to adopt new behaviors includes gaining knowledge of the risks and benefits of behavior change, developing self-efficacy, assessing outcome expectations of the change in behavior, setting health goals and strategizing to realize those goals, and overcoming social and structural perceived impediments to health behavior change (Bandura, 1986; 2004).

This theory is evident in several communities and interventions. A study among a nationally representative sample in Nigeria found misinformation about family planning to have a negative effect on contraceptive use and accurate information to have a positive effect on use (Ankomah, Anyanti, & Oladosu, 2011). Myths and misinformation negatively related to contraceptive use included the belief that contraception makes women become promiscuous, contraception causes cancer, and contraception is expensive (Ankomah, Anyanti, & Oladosu, 2011). Moreover, other literature suggests that accurate knowledge is positively associated with increased contraceptive use and intentions (e.g., Alvarez et al., 2010; Credé et al., 2012; Duong, Lee, & Binns, 2005). The study therefore attempted to find out to what extent social cognitive theory was applicable in indicating factors that influence male involvement in family planning initiatives. Based on this theory, the researcher hopes that solutions for enhancing male involvement in family planning would be suggested.
2.8 Conceptual Framework

This study was guided by the following conceptual framework:

**Fig. 2.1: Conceptual Framework**

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Intervening Variables</th>
<th>Moderating Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge on FP</td>
<td>No. of living children</td>
<td></td>
</tr>
<tr>
<td>Spousal communication</td>
<td>Taboos</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Availability of FP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Affordability of FP</td>
<td></td>
</tr>
<tr>
<td><strong>Strategic factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Design</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Economic factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmet need for FP</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cultural factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fertility preferences</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Key</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Represents Directional Relationship</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.8.1 Relationship between the variables in the conceptual framework

In the study, the dependent variable being investigated was male involvement in family planning initiatives and the independent variables are the factors that influence male involvement in family planning initiatives. These factors include strategic factors (FP method and FP project design), social factors (religion, gender, knowledge of FP, spousal communication), economic factors (income and unmet needs) and cultural factors (fertility preference and perceptions). Male involvement in family planning was measured in terms of Approval of FP, Joint decision making on FP, Utilization of FP methods, Shared Responsibility on FP and Support of Partner on FP. Hossain (2003), for instance found that husband’s preference for more additional children were decreasing the probability to use family planning method. Also, Ongango et al. (2010), points out that the limited methods of FP for men namely vasectomy and condoms make men less involved as they live the duty of controlling pregnancies in the hands of their spouses. However, the extent of the correlation is further influenced by moderating factors such as the number of living children that the couple has, cultural taboo related to FP and level of campaign and advocacy and age of the man, availability and affordability of Family planning methods. Even though these factors were not investigated in this study, various other studies (Kabagenyi et al. 2014; KNBS, 2010; Hossain, 2003; Onyango et al. 2010; Ankomah et al. 2011) have shown that such factors can influence male involvement in family planning initiatives. Intervening variables such as government policy on family planning and political will can influence male involvement in FP initiatives. For instance, if the government has a clear policy for male involvement in family planning, then more men will be involved as good environment will have been created for partners and stakeholders to usefully intervene.
2.9 Knowledge Gap

The global, regional and local review of literature revealed that no research has been undertaken in the present area of study which proposes to identify and analyze the strategic, social, economic and cultural factors influencing male involvement in family planning in Kakamega East Sub County. The literature reviewed also revealed that most of the research conducted in this area include a mix of both men and women and none samples only men. Research on this area is therefore very significant as it will help to fill the knowledge gap that presently exists regarding the factors influencing male involvement in family planning in Kakamega East Sub County.

2.10 Summary of Literature Review

The literature reviewed covered global, regional and local perspectives on the concepts of family planning, male involvement as well as the factors influencing male involvement in family planning initiatives. The researcher reviewed literature extensively on the correlation between FP method, FP project designs, level of education, gender, religion, spousal communication, knowledge on FP, Unmet needs for FP, level of income, perceptions and fertility preference on male involvement on family planning initiatives.
CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This section describes how the study will be conducted in order to achieve its objectives. The section includes a discussion of the research design, target population, sample size and sampling procedure, description of research instruments, validity and reliability of instruments as well as the procedures of data analyses and ethical issues considered in the study.

3.2 Research Design

Descriptive survey research design was adopted in this study. According to Kombo and Tromp, (2006), descriptive research involves the description of state of affairs as it exists. Orodho (2003) adds that descriptive survey is a method of collecting information by interviewing or administering questionnaire to a sample of individuals. Survey research involves acquiring information about one or more groups of people – perhaps about their characteristics, opinions, attitudes, or previous experiences – by asking them questions and tabulating their answers. The ultimate goal is to learn about a large population by surveying a sample of that population. In this study, the survey research design has been chosen owing to its versatility, efficiency, and generalizability. Surveys are efficient in that many variables can be measured without substantially increasing the time or cost. In addition, this method lends itself to probability sampling from large populations. Since sample generalizability is a central goal for this research, this design has been chosen. In fact, Weiss et al., (2001), points out that survey research is often the only means available for developing a representative picture of the attitudes and characteristics of a large population.
3.3 Target Population

The study population consisted of male household heads between the ages 18-55 years from the 29,128 households in Kakamega East Sub County. The Sub County has a total projected household population size of 29,128 households in 2015 based on the 2009 Household Survey and Population Census (KNBS, 2010). In this study, households were targeted because the study focused on the residents of the Sub County who can be best found in households as opposed to meeting them in the streets. This population was also selected because it is concerned about and make critical decision on fertility and family planning in their households.

3.4 Sample Size and Sampling Procedure.

3.4.1 Sample Size

Amin (2005) describes a sample as elements of a population that is subjected to the research questions. According to Babbie (2001), working with a sample reduces the length of time needed to complete research, cuts cost, is manageable and is almost a mirror of the entire population. With a confidence level of 95% and level of precision of 0.05, and a population size of 29,128, the sample size for the study was calculated using the simplified formula developed by Yamane (1967) for calculating sample sizes as follows:

\[ n = \frac{N}{1 + N(e)^2} \]

Where

- \( n \) is the sample size,
- \( N \) is the population size (29,128),
- \( e \) is the level of precision (0.05).
Applying this formula to the sample above

\[ n = \frac{29,128}{1 + 29128 \times 0.05^2} \]

=395

Therefore the sample size for the study was 395 male household heads aged 18-55 years from Kakamega East Sub County.

3.4.2 Sample Selection Procedure

Simple Random sampling technique was used to sample the men to participate in the survey. According to Moore and McCabe (2006), simple random sampling is a type of random sampling where the variables have an equal and unsystematic chance of selection is a subset of population in which each member has an equal probability of being sampled. It is meant to be an unbiased representation of the population. This method has been chosen based on its ability to give all the men in the study population equal chance to be sampled in the study, thus making the findings generalizable to the population. The 29,128 male household heads had equal chance of being sampled. In selecting the sample, the researcher randomly selected 395 male households distributed across the study area.

3.5 Data Collection Instruments

Data for the study was collected through questionnaires.

3.5.1 Questionnaire

A questionnaire consists of a set of structured questions that the respondents will be expected to respond to appropriately. Kothari (1990) argues that a questionnaire can be used to collect data from a large number of respondents. In this study, the questionnaire
was used to collect data from 395 respondents aged between 18 – 55 years. The questionnaire had five sections, with section one capturing demographic information of the respondents while section two to five each captured the independent variables. The questionnaire was administered by the researcher assisted by four trained enumerators. A canvasser method, in which the enumerators recorded the responses from the respondents, was adopted. Both open ended and closed ended questions were contained in the questionnaire to generate more information on the subject matter of the study. Since, questionnaires are a quantitative data collection tool, the data that was collected was mainly quantitative in nature. The researcher did not record the respondents name or identifier on the questionnaire. Instructions to the research assistants administering the questionnaire was included to guide the collection of reliable and valid data and the principles of confidentiality and informed consent was maintained throughout the study.

3.5.2 Pre-testing

Pre-testing is a preliminary study conducted before the final study begins to ensure that the research instruments are working properly (Ouma, 2010). In this study the data collection tools were pre-tested in Majengo village in Vihiga County to ensure that questionnaire items are clearly presented so that respondents understand and interpret the questions or items in the same way and that the tool bears the same meaning to all respondents. Five (5) male respondents were selected randomly for the pretesting. This was to help increase the reliability, clarity and friendliness of the tools as well as evaluate the length of time taken to administer the tool. Majengo Sub County was chosen as pre-testing site because it substantially shares characteristics with the actual study area namely they are both Luhya communities, are in western Kenya and have similar socio-cultural backgrounds. The pre-testing adopted the sampling procedures and techniques
guiding the main study. The challenges and problems noted in the pre-testing stage such as vagueness, lack of clarity, repetition and length of time among others were used the researcher to review, redesign and adjust the question in such a manner as to make the tool clearer and free from vagueness. This was done to improve the efficiency of the tools and maximize response rate since respondents will be able to answer the questions without difficulty. The information obtained from the pre-testing stage was used to develop dummy tables and the format of the results section in the draft report. This made the preparation of the draft report easy when study data was finally collected, analyzed and interpreted.

3.5.3 Validity of the Instruments

According to Brains et al., (2011), validity is the degree to which a measurement tool measures what it claims to measure. In this study, validity of the instrument was achieved by using simple language when constructing instruments for respondents for easy understanding. Side notes were also used to guide respondents and enumerators. Before the instruments were finally administered, the university supervisors reviewed the instruments to ensure validity. The research team ensured that research questions were answered by the respondents as completely as possible. Where possible, the respondents were contacted to provide clarifications on their responses to ensure that full validity of the instruments were achieved.

3.5.4 Reliability of the Instruments

According to Cozby (2001), reliability is the degree to which an instrument produces stable and consistent results. Reliability of the questionnaire was made possible by ensuring that the number of the questions on the questionnaires were fairly many so as
to cover as many research issues as possible. Pre-testing of the tool was also done in Majengo village with 5 male respondents to ensure that the final questionnaire is reliable. The random errors that could possibly reduce reliability were minimized by giving clear instructions to the respondents, training research assistants and coding the questions accurately.

3.6 Data Collection Procedure

Semi-structured questionnaire were developed and used for data collection in the study. This instrument was pretested before they were used in the actual study. The researcher discussed the instrument thoroughly with the research supervisors to make sure that it offers the highest level of validity and reliability. The instrument was further discussed with the research assistants to ensure that they understood and were well acquainted with the instruments before data collection. The improved versions of the instruments were then be used for the pretesting exercise. Both pretesting and actual data collection were conducted in Kiswahili and English and translations were done for participants who only understand the local Isukha language.

The researcher made 395 copies of questionnaires which were administered by the research assistants on the study sample. During the data collection, oral consent of all the respondents were obtained and the objectives and procedure of the study were thoroughly explained to them. The researcher supervised all data collection to ensure quality control. All study participants were encouraged to openly discuss their opinions and no personal information in the form of names or other identifying data of the respondents were obtained.
3.7 Data Analysis Techniques

The completed copies of the questionnaire were serially numbered for control and recall purposes. The data collected were checked for completeness and accuracy as they streamed in on a daily basis. The quantitative data collected were collated, coded and screened for completeness. Statistical Package for Social Science (SPSS) version 19 were used for the coding and analysis of the data. The data was analyzed at bivariate level of analysis in which the relationship between male involvement and the independent variables was examined.

3.8 Ethical Considerations

Rensik (2011) defines ethical considerations as principles that protect the rights of participants in a research study. They are actions taken to ensure that the safety and rights of participants are not violated during the entire process of the study. According to Shamoo and Resnik (2009), these standards include voluntary participation, informed consent, confidentiality of information, anonymity of research participants and approval from relevant authorities to undertake research studies. In this study, participants were informed of all the procedures, benefits and risks involved in the research and were allowed to take part in the study voluntarily. Prior to participation informed consent was obtained from all study participants and no participant was asked to indicate their name or any other personal identifier. The researcher also ensured that only the research team had access to the study data to maintain confidentiality and integrity of the data. In addition authorization for the study was sought from the National Council of Science and Technology and approval from the University of Nairobi. The research supervisors scrutinized the research instruments to ensure that the items contained in them had no negative effect on the respondents and were not likely to violate any of their rights.
CHAPTER FOUR
DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSIONS

4.1 Introduction
This chapter presents findings of the study which have been discussed under thematic sub-sections in line with the objectives of the study. The thematic areas include questionnaire return rate, demographic characteristics of respondents, influence of strategic factors on male involvement in family planning, influence of social factors on male involvement in family planning, influence of economic factors in family planning and influence of cultural factors in family planning.

4.2 Questionnaire Return Rate
The study targeted 395 male household heads within the 18-55 age bracket within Kakamega East Sub County. A total of 395 questionnaires were administered and all of them were returned giving a response rate of 100%. The high response rate from the respondents was attributed to the fact that the questionnaires were collected immediately the respondents finished answering the questions and to the fact that some were directly administered by the research team on those who were unable to read or write. In the opinions of Amin (2005), a return rate of above 60% is good and suitable for analysis. Therefore, the response rate of 100% achieved by this study was indeed sufficient for analysis and reporting.

4.3 Demographic characteristics of respondents
This section presents the demographic characteristics of the study respondents. The demographic characteristics considered in the study included Age (from 18 to 55 years), marital status (single, married), level of education (primary, secondary, tertiary college, university and none), average monthly income and religious affiliation (Catholic, Protestant, Muslim, None and other).
4.3.1 Distribution of Respondents by Age

The researcher asked respondents their ages because this could determine their level of experience in family planning matters and their need for family planning services and information. The age of respondents could also reveal the level of commitment and responsibilities they had in their marriage or sexual relationships. The age distribution of respondents is presented in Table 4.1.

Table 4.1: Distribution of Respondents by Age

<table>
<thead>
<tr>
<th>Age group</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>89</td>
<td>22.5</td>
</tr>
<tr>
<td>26-35</td>
<td>169</td>
<td>42.8</td>
</tr>
<tr>
<td>36-45</td>
<td>80</td>
<td>20.3</td>
</tr>
<tr>
<td>46-55</td>
<td>57</td>
<td>14.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>395</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.1 shows that 169 (42.8%) of the respondents were within age bracket 26-35, followed by 89 (22.5%) of them in age group of 18-25, 80 (20.3%) were in age group 36-45, while the least number of respondents were in age group 46-55 being 57 (14.4%). Based on the statistics, it appears that the majority of those who participated in the study were in the young bracket. This was considered a suitable group in the analysis of factors influencing male involvement in family planning in Kakamega East Sub County, partly because of their sexual activity and suitability of being considered a good target group for family planning programs, projects and activities.

4.3.2 Distribution of Respondents by Marital Status

The study also sought to establish the marital status of the respondents. In order to establish this, the researcher asked the respondents whether they were married or single.
Respondents who were widowers, divorcees or separated were considered as single at the time of the survey. This information was important to the researcher because it revealed the level of possible sexual activity and need for family planning services and information. In order to capture this very important information, the respondents were asked to indicate their marital status. This is shown in Table 4.2.

**Table 4.2: Distribution of Respondents by Marital Status.**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>329</td>
<td>83.3</td>
</tr>
<tr>
<td>Single</td>
<td>66</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>395</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.2 shows that 329 (83.3%) were married or had sexual partners while those who were single at the time of the survey were 66 (16.7%). From the results in Table 4.2, it is clear that the majority of the respondents were married, thus in active sexual relationship. This proposition was important in the analysis of factors influencing male involvement in family planning mainly because of their sexual activity.

**4.3.3 Distribution of Respondents by Level of Education**

The study sought to establish the level of education of the respondents. Level of education was considered important in this study because it could reveal information in the role of level of education in influencing male involvement in family planning among the study population. The researcher believed that level of education determined the respondent’s exposure to information and world views. The respondents were asked to state their highest level of education. Their responses were as tabulated in Table 4.3.
Table 4.3: Distribution of Respondents by Level of Education

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>99</td>
<td>25.5</td>
</tr>
<tr>
<td>Secondary</td>
<td>158</td>
<td>40.7</td>
</tr>
<tr>
<td>Tertiary College</td>
<td>84</td>
<td>21.6</td>
</tr>
<tr>
<td>University</td>
<td>26</td>
<td>6.7</td>
</tr>
<tr>
<td>None</td>
<td>21</td>
<td>5.4</td>
</tr>
<tr>
<td>Missing</td>
<td>7</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>395</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

In table 4.3, a total of 158 (40.7%) of the respondents had secondary education followed by those with primary education at 99 (25.5%) which was followed closely by those with tertiary education at 84 (21.6%). Those with university education were 26 (6.7%) while those without any education were 21 (5.4%). Those who did not indicate their highest level of education were 7 (1.8%). The results of this table generally shows that a majority of the respondents 268 (67.9%) had attained post primary education, thus were literate.

4.3.4 Distribution of Respondents by Monthly Income

The study sought to establish the monthly income of respondents. Establishing this was considered important in the study because it could influence the ability of the respondents’ in as far as acquiring family planning services and products. In order to establish this, the respondents were asked to indicate their estimated monthly income as presented in table 4.4.
Table 4.4: Distribution of Monthly Income of Respondents

<table>
<thead>
<tr>
<th>Average Monthly Income (Ksh)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5,000</td>
<td>115</td>
<td>29.1</td>
</tr>
<tr>
<td>5,001-10,000</td>
<td>121</td>
<td>30.6</td>
</tr>
<tr>
<td>10,001-20,000</td>
<td>88</td>
<td>22.3</td>
</tr>
<tr>
<td>20,000 – Above</td>
<td>71</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>395</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.4 shows, that 115 (29.1%) of the respondents had average monthly income lower that Ksh. 5,000, 121 (30.6%) had average monthly income below Ksh. 10,000 while 88 (22.3%) of the respondents had income below Ksh. 20,000. Only 71 (18%) had average monthly incomes above Ksh. 20,000. This shows that a majority of the respondents lived way below the poverty. These results therefore shows that a majority of the respondents had low ability to access and acquire some of the non-free family planning services and products such as vasectomy.

4.3.5 Distribution of Respondents by Religious Affiliation

The study also sought to establish the religious affiliation of respondents. This was considered important as religion could influence the position one held in regards to the issues of involvement in family planning. To establish this important demographic characteristic, the respondents were asked to state their religious affiliations as presented in table 4.5.
Table 4.5: Religious Affiliations of Respondents.

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>116</td>
<td>29.4</td>
</tr>
<tr>
<td>Protestant</td>
<td>222</td>
<td>56.2</td>
</tr>
<tr>
<td>Muslim</td>
<td>28</td>
<td>7.1</td>
</tr>
<tr>
<td>None</td>
<td>24</td>
<td>6.1</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>395</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

From table 4.5, the study results show that 222 (56.2%) of the respondents were from protestant churches while 116 (29.4%), 28 (7.1%) and 24 (6.1%) were Catholics, Muslim and none believers respectively. The study also revealed that 5 (1.3%) belonged to other unspecified religions. These results show that most the majority of respondents 366 (92.7%) were religious believers with a sweeping majority 338 (92.4%) being Christians.

4.4 Influence of social factors on male involvement in family planning initiatives

This section sought to present the findings of the study in an effort to establish the extent to which social factors influence male involvement in family planning initiatives. This was done under four sub-themes namely: gender roles, knowledge on FP, religion and spousal communication.

4.4.1 Influence of Gender Roles on Male Involvement in Family Planning Initiatives

The researcher examined the influence of gender roles on male involvement in family planning. To establish this relationship, two questions were presented to the respondents. When asked whether a man should concern himself with issues of family planning, 214 (66.7%) agreed that indeed a man should involve himself with issues of FM
while 107 (33.3%) indicated that FP is an issue of women and no man should involve himself in such issues. Table 4.6 presents the responses regarding this question.

Table 4.6: Male Concern with FP issues

<table>
<thead>
<tr>
<th>Male concern on FP</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>214</td>
<td>66.7</td>
</tr>
<tr>
<td>No</td>
<td>107</td>
<td>33.3</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100</td>
</tr>
</tbody>
</table>

Further, the researcher sought to establish the reasons for the response given above. As to this, those who said that a man should never concern himself with the issues of family planning gave reasons including ‘you will be ridiculed by other people’ while those saying that a man should gave reasons including ‘family is for both men and women and the involvement of a man is crucial’. Providers seeking to promote sexual and reproductive health for men in western Kenya should be sensitive to the fact that if men are not taking full responsibility for their sexual and reproductive behavior, the reason may be that they are acting within a set of cultural norms that determine gender relations. For reproductive health programs to benefit both men and women, they should be based on a better understanding of gender dynamics in the region. The responses on who should make decisions on the use of family planning in the family, the responses were as in table 4.7.
Table 4.7: Decision making on FP

<table>
<thead>
<tr>
<th>Decision making</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Man</td>
<td>9</td>
<td>2.8</td>
</tr>
<tr>
<td>Woman</td>
<td>64</td>
<td>20</td>
</tr>
<tr>
<td>Both</td>
<td>232</td>
<td>72.5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>15</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>320</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Results in tables 4.6 shows that a majority of the respondents agreed that men should concern themselves with issues of FP, however, table 4.7 indicates that a man should hardly have decisional role in the use of FP (2.8%) but that the choice should be made jointly by both the woman and the man (72.5%). The study findings that 20% of the respondents are of the opinion that a woman should have full role in making decisions on family planning confirms the fears from the study by Boender et al., (2004), that women’s ability to make sole decision on FP is limited and thus takes away the independence of the woman. Further, the findings explain that even though the respondents felt that men should have very little decisional role at 2.8%, 72.5% still felt that men consulted by women on any decisions regarding family planning. Further, the findings of the study is in line with the finding of the Kenya Demographic and Health Survey 2008-09 in which 16% of men believed that FP is a woman’s business and that a man should not have to worry about it (KNBS, 2010).

However, these findings conflict with those done in Malawi by Soldan (2004)which concluded that men dominated decision making in family planning decisions.
4.4.2 Influence of Religion on Male Involvement in Family Planning Initiatives

Religion influences human behavior fundamentally. In order to establish the influence religion has on male involvement in family planning initiatives, the researcher asked the respondents whether their religion accepted the practice of family planning. Of those who responded to this question 249 (69.7%) indicated that their religion was against the practice of family planning while 108 (30.3%) indicated that their religion accepted the practice. When asked of their personal opinion on the religious position, 218 (66.1%) responded that family planning was a personal choice and not the choice of the church. Those who did not accept the practice of FP indicated that their church teaches against family planning 58(17.6%) while 51(15.1%) indicated that FP is equivalent to killing. The findings are in line with those by Schenker and Rabenou, (1993) and Schenker, (2000) in which they reported that some religions (Catholic and Muslim) considered the act of intercourse must be open to conception and that any contraception destroys any potential to produce new life and thus violates the principal purpose of marriage. These findings further corroborate the findings of a study done by Sileo (2014) in Uganda in which he concluded that mobilization for family planning programs were hindered by the position of some religions.

However, from these findings it is evident that even though religion influences male involvement in family planning, personal choice was a very important factor in determining the ultimate decision on male involvement in family planning being that 66.1% percent accepted that they will go with personal choice principle on this matter.
### 4.4.3 Influence of Spousal Communication on Male Involvement in Family Planning Initiatives

The researcher sought to establish this relationship by asking the respondent how often they discussed issues of family planning with the partners and whether such discussion influenced their involvement in family planning initiatives. The responses were as detailed in the table 4.8.

**Table 4.8: discussion of family planning with partner**

<table>
<thead>
<tr>
<th>Frequency of discussion of FP</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly</td>
<td>152</td>
<td>39.8</td>
</tr>
<tr>
<td>Occasionally</td>
<td>112</td>
<td>29.3</td>
</tr>
<tr>
<td>Never</td>
<td>118</td>
<td>30.9</td>
</tr>
</tbody>
</table>

Table 4.8 shows that 39.8% men regularly discussed the issues of family planning with their partners, 39.3% occasionally discussed while 30.9% had never discussed the matter with their partners. Those who had never discussed FP with their partners mentioned several reasons including; fear of being ridiculed (38.1%), FP being a woman’s issue (14.8%), lack of information on FP (12.3%), Disapproval of FP (11.4%) while those who did so for other unspecified reasons constituted 24.1%.

Those who ever discussed FP with their partners when asked whether such discussion influenced their opinion towards getting involved responded as in table 4.13.
Table 4.9: Influence of Spousal Communication on Male Involvement in Family Planning.

<table>
<thead>
<tr>
<th>Did the FP discussion influence you</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>214</td>
<td>79.6</td>
</tr>
<tr>
<td>No</td>
<td>55</td>
<td>20.4</td>
</tr>
</tbody>
</table>

From Table 4.9, it is seen that a majority of the respondents (79.6%) agreed that in discussing FP with their partners, they were influenced to be more involved while 20.4% percent said that such discussions did not influence them significantly in anyway. These findings prove that spousal communication is an important precursor to the adoption of family planning methods. These findings are consistent with those of Antenane (2002) in Ethiopia that concluded that spousal communication was an important precursor to the adoption of family planning. According to the study couple who discussed family planning regularly were 40% more likely to adopt family planning.

The findings of this study in regards to the influence of spousal communication also corroborates the findings of a study conducted in Nigeria by Oni and McCarthy (1991) in which they reported positive correlation between communication and contraception use. Locally, the findings are consistent with those of Lasee and Backer (1997) who analyzed the 1989 Kenya Demographic Health Survey and found statistically positive correlation between husband and wife communication about family planning and contraceptive use, even after controlling for background factors which may have been confounding.
4.4.4 Influence of Knowledge of FP on Male Involvement in Family Planning Initiatives

The researcher examined the influence of knowledge of FP on male involvement in family planning. To establish this relationship, the respondents were asked, among others, to list the FP methods they know of. The findings on this question were as listed in table 4.10

Table 4.10: FP methods known by respondents.

<table>
<thead>
<tr>
<th>FP Method</th>
<th>Have heard about</th>
<th>Have not heard about</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Implants</td>
<td>274</td>
<td>73.5</td>
</tr>
<tr>
<td>Pill</td>
<td>353</td>
<td>93.9</td>
</tr>
<tr>
<td>Injectable</td>
<td>348</td>
<td>94.3</td>
</tr>
<tr>
<td>Male condom</td>
<td>386</td>
<td>97.7</td>
</tr>
<tr>
<td>IUD</td>
<td>206</td>
<td>55.1</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>242</td>
<td>63.9</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>234</td>
<td>59.7</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>243</td>
<td>60.6</td>
</tr>
<tr>
<td>LAM</td>
<td>144</td>
<td>36.5</td>
</tr>
<tr>
<td>Female condom</td>
<td>324</td>
<td>82</td>
</tr>
<tr>
<td>Emergency</td>
<td>212</td>
<td>53.7</td>
</tr>
</tbody>
</table>

As shown in table 4.10, the respondents had sufficient knowledge in most of the FP methods. Level of knowledge on male condoms, Injectable, pills, female condom and implants topped the list at 97.7%, 94.3%, 93.9%, 82% and 73.5% respectively. The study
revealed that the least known FP methods were LAM that was known by only 36.5% and Emergency Contraceptive known by 53.7 percent of the population. Even though table 4.10 shows that 97.7% of the population knew about male condoms, only 58.5% of the respondents ever used male condoms in the six months preceding the study. This shows that knowledge alone may not translate into utilization. This supports a study done in Uganda by Chipeta, Chimwaza and Kalilani-Phiri (2010) in which they demonstrated low use of contraception among populations with high knowledge. Further, these findings are consistent with more recent findings in Kenya, Ghana in which the researchers found that accurate knowledge on FP is positively associated with increased contraceptive use and intentions (Alvarez et al., 2010; Oketch, Wawire and Mburu, 2011).

The researcher further sought to establish the source of information on the methods mentioned by the respondents. Forty three percent (43.9%) of the respondents indicated mass media (radio, TV and internet) as their source of information, followed by seminar/trainings and spouses at 31.2% and 14.9% respectively. Only 0.2% of the respondents heard the information from their children.

Finally, on the issue of knowledge, the researcher also sought to determine the opinion of the respondents on the influence of knowledge on FP in male involvement in family planning. Responses of respondents on this matter were tabulated in table 4.11.
Table 4.1: Opinion of respondents on the Influence of FP Knowledge on Male Involvement in Family Planning Initiatives.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of FP determines the choice of a method to use</td>
<td>157 (42)</td>
<td>160 (42.8)</td>
<td>41 (11)</td>
<td>18 (4.3)</td>
</tr>
<tr>
<td>Knowledge of FP influences how one handles side effects of FP</td>
<td>94 (24.4)</td>
<td>184 (47.7)</td>
<td>97 (25.1)</td>
<td>11 (2.8)</td>
</tr>
<tr>
<td>Knowledge enables a man to support partner on FP</td>
<td>100 (26.6)</td>
<td>230 (61.2)</td>
<td>44 (11.7)</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Knowledge does not influence a man’s involvement in FP</td>
<td>4 (1)</td>
<td>104 (26.9)</td>
<td>237 (61.4)</td>
<td>41 (10.6)</td>
</tr>
</tbody>
</table>

Table 4.11 shows the responses of respondents when they were asked their level of agreement with various statements targeted at gauging their opinion on the influence of knowledge on male involvement in family planning. From the table, a majority of the respondents (42.8%) agreed that knowledge of FP determined the choice of FP method a man would use as well as his ability to engage with FP related initiatives. In addition, 87.7% of the respondents agreed or strongly agreed that knowledge on FP enabled a man to support his partner on the use of FP. Only 1% strongly agrees with the statement that knowledge has no influence on male involvement in family planning. These findings corroborate the findings from a study in Bangladesh that showed that male involvement in family planning and reproductive health is higher at 78.8% among men who have high knowledge on contraception, while male involvement in family planning is lower at 39.8% among those who did not have adequate knowledge on contraception (Kamal et al., 2013).
4.5 Influence of Strategic Factors on Male Involvement in Family Planning Initiatives

The researcher also sought to determine the influence of strategic factors on male involvement in family planning among the study population. The variables used in analyzing this were FP project design methodologies and methods of FP.

4.5.1 Influence of family planning method on male involvement in family planning initiatives.

The researcher wanted to determine the influence that the method of Family Planning had on male involvement in family planning among the respondents. When asked whether they have used any modern family planning method in the last 6 months, the responses were as in the table 4.12.

<table>
<thead>
<tr>
<th>Ever used modern FP in the last 6 months</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>230</td>
<td>58.5</td>
</tr>
<tr>
<td>NO</td>
<td>163</td>
<td>41.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>393</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The table shows that 58.5% of the respondents had used a modern FP method in the six months preceding the survey while 41.5% had never used any method in the same period. Of those who had used a Family planning method in the last six months, 100% of them used male condoms. This findings on the level of use of condoms shows marked improvement from a survey conducted in 2004 by Kenya National Burea of statistics that indicated that condom use was at 0.3% in western Kenya (KNBS, 2004). Male condom was the preferred choice by the respondents because of several reasons. A majority
(53.3%) said that condoms was convenient because one can use and discontinue it anytime they wanted without any complications, 31.3% of the respondents however pointed out that they preferred it because it’s a popular method with less side effects while 14.8% mentioned that they preferred male condoms because they was cheaper. The reasons provided by the study respondents corroborate those reported by Onyango et al (2010) in a study they conducted in western Kenya.

When asked whether they could consider going for vasectomy, 83.9% of the respondents said they would not whereas only 16.1% said they could consider vasectomy. When asked for the reasons they would not consider vasectomy an FP method, the respondent provided the following responses as detailed in table 4.24.

Table 4.13: Reasons for not consider undergoing Vasectomy.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is costly</td>
<td>76</td>
<td>13.1</td>
</tr>
<tr>
<td>I will not be able to have other children</td>
<td>241</td>
<td>41.4</td>
</tr>
<tr>
<td>My wife will be promiscuous</td>
<td>33</td>
<td>5.7</td>
</tr>
<tr>
<td>I do not know where it is done</td>
<td>56</td>
<td>9.6</td>
</tr>
<tr>
<td>I am afraid of the procedure</td>
<td>115</td>
<td>19.8</td>
</tr>
<tr>
<td>I do not have information about it</td>
<td>49</td>
<td>8.4</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>582</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.13 shows that a majority of the people (41.4%) would not go for vasectomy because they would not be able to father anymore children. Fear for the procedure was given by 19.8%, while cost was pointed out by 13.1% of the respondents, whereas knowledge of where it is done, lack of information on the procedure and fear of
wife being promiscuous had 9.6%, 8.4% and 5.7% respectively. This shows that most men wanted to always have the ability to father children even if they may want to limit or space their children. This findings support those made by EngenderHealth (2014), in which they concluded that since vasectomy is an irreversible and costly procedure its acceptance still remain considerably low with only 0.4% of the population having undergone it. The reasons given for low consideration of vasectomy by the of the study respondents are also in line with the findings in a report of a study conducted by KMET in western Kenya 2009 which revealed that men did not want to undergo vasectomy because they believed that it would make them unable to have sex, hence harming their standing in the society as well as cause their spouses to look for other partners (UNFPA, 2009)

4.5.2 Influence of Project Design on Male Involvement in Family Planning Initiatives

The researcher sought to understand whether project design practices influenced male involvement FP initiatives or not. To establish this the researcher asked the respondents to state if they had ever been involved in the design, formulation or planning of any FP program in the area and those who had not were asked to reasons for their non-participation. Table 4.14 shows involvement of the respondents in the design of FP initiatives.

<table>
<thead>
<tr>
<th>Involvement on design of FP initiatives</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>100</td>
<td>49.3</td>
</tr>
<tr>
<td>NO</td>
<td>103</td>
<td>50.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>203</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
From table 4.14, 50.7% of the respondents indicated that they had never participated in any design process on any FP program where as 49.3 indicated that they had been involved at one time or another. These responses show that over half of the population never got involved in the ongoing project even though public and stakeholder participation is a requirement in project design by both public and private players. These findings support those by Olawepo and Okedare (2006) in which they concluded that developing countries, family planning services have been almost directed at women exclusively with little attention paid to men.

Those who never participated in the design of FP projects 53.4% indicated that they have never been invited to such forums, 25.2% indicated that the program involved women only, 13.6% said they did not know about it while 7.8% responded that they did have knowledge on this matter to be able to participate. These findings show that project designers still use traditional methodologies that focused on women ignoring the paradigm shift that emphasizes the involvement of men. This findings support the findings of a study conducted in western Kenya by Onyango et al (2010) in which they conclude that the traditional approaches used to design, plan and implement family planning initiatives have discouraged the participation of men in such initiatives. this further, confirms the report by UNAIDS (1999), that indicated that traditionally, family planning programs and projects are deliberately designed to target women since FP has been seen as feminine ideal while the needs of men have been neglected by those designing FP initiatives. Further, the findings by Hossain (2003), that this practice gives very little opportunity for male to receive service from family planning providers as well as get actively involved in family planning initiatives is corroborated by the findings of the study.
4.6 Influence of economic factors on male involvement in family planning initiatives

This section sought to present the findings of the study in an effort to determine the level at which economic factors influence male involvement in family planning initiatives. This was done under two sub-themes namely: unmet need for FP and Income.

4.6.1 Influence of income on male involvement in family planning initiatives

The researcher sought to establish the influence of income on male involvement in family planning initiatives among the respondents. When asked whether they were able to buy condoms for use every time they wanted to have protected sex, the responses were as in table 4.15.

<table>
<thead>
<tr>
<th>Are you able to buy condoms every time you want to have unprotected sex?</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>190</td>
<td>50.3</td>
</tr>
<tr>
<td>No</td>
<td>188</td>
<td>49.7</td>
</tr>
<tr>
<td>Total</td>
<td>387</td>
<td>100</td>
</tr>
</tbody>
</table>

From table 4.15 a total of 190 (50.3%) respondents concurred that they were able to buy male condoms anytime they wanted to have protected sex while the rest 188 (49.7%) indicated that they were unable to pay for male condoms whenever they wanted to have protected sex. This shows the 49.7% of the population would not be able to use male condoms as a family planning method, even though it is the most preferred most accessible and cheaper form of FP for men. These findings corroborate those of Kamal et al. (2013) conducted in Narsingdi municipality in Bangladesh, which indicates that income is associated with male involvement in family planning and reproductive health. In that study, the researcher found that about 45.4% of males whose income is less
than 10,000 taka, 65.3% with an income between 10,000 to 20,000 and 78.7% with an income of more than 20,000 taka per month are involved in family planning and reproductive health the Kamal et al., (2013) and this study both reveals that male involvement in family planning and reproductive health is proportionally higher among couples with higher income compared with whose that had lower income.

The researcher further sought to understand the alternatives available whenever the respondents were unable to buy condoms for use during sexual intercourse as presented on Table 4.16.

Table 4.16: Choices to use when respondent can’t afford condoms.

<table>
<thead>
<tr>
<th>Choice</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rely on the partners method</td>
<td>221</td>
<td>62.1</td>
</tr>
<tr>
<td>Stop using FP</td>
<td>27</td>
<td>7.6</td>
</tr>
<tr>
<td>Resort to natural method</td>
<td>78</td>
<td>27.1</td>
</tr>
<tr>
<td>Discontinue sex</td>
<td>30</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>356</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.16 clearly shows that 62.1% of the respondents would rely on the FP plan of the sexual partner, 27.1% would resort in using natural methods such as withdrawal. Only 8.1% would discontinue sex at the same time, while 7.6% would stop using the FP altogether. These findings are consistent with those by Speizer et al (2005), that found that in the burden of family planning is left on the shoulder of the women at all times and that men only carry a part of that responsibility when they chose to or when it is convenient.
4.6.2 Influence of unmet need for family planning on male involvement in family planning initiatives

In order to determine this relationship, the researcher asked two questions to the respondents. In question one, the researcher wanted to understand the modern family planning method that the respondents had access to. Table 4.17 shows the responses given by the respondents.

Table 4.17: Access to family planning methods

<table>
<thead>
<tr>
<th>FP Method</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Condoms</td>
<td>277</td>
<td>71.4</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>None</td>
<td>110</td>
<td>28.4</td>
</tr>
<tr>
<td>Total</td>
<td>388</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.17 shows that 71.4% of the respondents had access to male condoms while less than 1% had access to vasectomy whereas 28.4% had access to none of these methods. This corroborates the findings by Jacobstain and Pile (2007), that access to vasectomy in Sub-Saharan Africa, Kenya included remained at less than 1%.

When asked on what modern method of family planning they desired to use but had no access to, the number of people who desired to use vasectomy but had no access were 12.8% of the respondents, while 87.5% desired to use condoms but had no access to them. The number of men with unmet need for both condoms and vasectomy in this study was 50.1% compared to 23% in 1997. The high level of unmet need for men in the study corroborates the finding by Becker S.(1999) who also concluded that the high level of unmet need for family planning in the country greatly affects male involvement in FP and
shows that family planning initiatives are not meeting men’s demand for family planning (Becker S.1999).

4.7 Influence of cultural factors on male involvement in family planning initiatives

The researcher also sought to establish the influence of cultural factors in male involvement in family planning initiatives in Kakamega East Sub County. The parameters for analyzing this relationship were perception and fertility preferences.

4.7.1 Influence of perception on male involvement in family planning initiatives

The study sought to gather the level of agreement with certain statement aimed at analyzing the perception of the respondents on the subject of male involvement in family planning initiatives. The perceptions were measured in Likert scale containing Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD) as analyzed in table 4.18.

<table>
<thead>
<tr>
<th>Statement</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
</tr>
<tr>
<td>Family planning encourages promiscuity in women</td>
<td>44 (13.7)</td>
<td>39 (12.1)</td>
<td>114 (35.5)</td>
<td>124 (38.6)</td>
</tr>
<tr>
<td>Condom use reduces sexual pleasure in men</td>
<td>10 (3.0)</td>
<td>109 (32.5)</td>
<td>126 (37.6)</td>
<td>90 (26.9)</td>
</tr>
<tr>
<td>Men in manual labour should not undergo vasectomy</td>
<td>8 (2.4)</td>
<td>87 (26)</td>
<td>123 (36.7)</td>
<td>117 (34.9)</td>
</tr>
<tr>
<td>Family planning makes a woman cold in bed</td>
<td>3 (0.9)</td>
<td>23 (6.9)</td>
<td>153 (47.9)</td>
<td>156 (46.4)</td>
</tr>
<tr>
<td>Vasectomy is synonymous to castration</td>
<td>11 (3.3)</td>
<td>141 (42.1)</td>
<td>89 (26.6)</td>
<td>94 (28.1)</td>
</tr>
</tbody>
</table>

Table 4.18 shows that 25.9% constituted those who tended to agree with the perception that FP encourages promiscuity among women while 74.1% tended to the disagreeing side. This indicates that the perception, though existing, is not significant. This finding disagrees with an earlier study finding by Okwor and Olehesa (2010) in
Nigeria in which they concluded that the majority of the male respondents were unanimous that allowing a woman to use modern contraceptives gives room for infidelity on the part of the woman.

On the perception that condom use reduces sexual pleasure in men, 41.1% tended to the agreeing side while 58.9% tended to the disagreeing side. This shows that this perception is significant among the respondents. This finding supports the findings from another study conducted by Kabagenyi et al. (2014) in Uganda in which they report that a commonly reported disincentive among men to support their partner’s use of contraceptive methods related to perceived side effects which were blamed for reducing sexual pleasure among both men and women.

On the perception that men involved in manual labour should not go for vasectomy 34.2% tended to the agreeing side while 65.8% tended to the disagreeing side. Therefore the study revealed that the belief that vasectomy is for those in white caller jobs holds significant position among the respondents.

The respondents were also asked of their perception that vasectomy is synonymous to castration. The responses indicate that 51.3% of the respondents tended to the disagreeing side while 48.7% tended to agree with this statement. The perception therefore has statistical significance since almost a half the population believes that vasectomy is equivalent to male castration. This agrees with a finding by UNFPA (2009), in Nyanza and Western Kenya in which they concluded that a wide-spread perception was that vasectomy would render them unable to have sex.

4.7.2 Influence of fertility preferences on male involvement in family planning initiatives

The study sought to establish the role fertility preferences played in influencing male involvement in family planning among the respondents. The study sought to
establish the number of children preferred by the respondents and whether they are willing to use FP for limiting or spacing their children. Table 4.19 analyzes the fertility preference by the respondents.

Table 4.19: Fertility Preferences

<table>
<thead>
<tr>
<th>Fertility preferences (No of Children)</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>11</td>
<td>2.8</td>
</tr>
<tr>
<td>1-2</td>
<td>106</td>
<td>27</td>
</tr>
<tr>
<td>3-5</td>
<td>199</td>
<td>50.6</td>
</tr>
<tr>
<td>6- Above</td>
<td>77</td>
<td>19.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>393</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.19 shows that 50.6% preferred 3-5 children, followed by those who preferred 1-2 children at 27% while those who preferred 6 and above children were 19.6% with those preferring no child at 2.8%. These results show that a majority of respondents (70.2%) preferred three children and above. This findings support those of Wambui (2012) in her study in western Kenya in which she concluded that Luhya men desired many children. these findings further supports those by Nganga (2009) in which he reported that men have a strong desire for large families. When the respondents were asked whether they would use FP for limiting or for spacing the children, the responses were as in table 4.20.
Table 4.20: Use of FP for limiting and spacing

<table>
<thead>
<tr>
<th>Use of FP</th>
<th>Respondents who accepted</th>
<th>Respondents who did not accept (NO)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>For Limiting the No. of children</td>
<td>200</td>
<td>50.6</td>
</tr>
<tr>
<td>For Spacing birth of children</td>
<td>303</td>
<td>76.7</td>
</tr>
</tbody>
</table>

Table 4.20 shows that 50.6% of the respondents would use FP for limiting the number of children they have while 49.5% at the time of the survey would not use FP for limiting the number of children they have. Alongside this, 76.7% of the respondents were willing to use FP to space children while 23.3 were unwilling to use FP for spacing children. These responses show that the need to space children was higher among the respondents compared to the need to limit the number of children.
CHAPTER FIVE
SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction
This last section of the report presents a consolidated summary of all the findings, discussions, relevant conclusions, study recommendations, contribution to knowledge and suggestions for further research.

5.2 Summary of Finding
From the findings in chapter four, the study was able to establish the factors that influence male involvement in family planning in Kakamega East Sub County, Kakamega County. The factors which were tested in the study were social factors, cultural factors, strategic and economic factors. These factors were further divided into sub theme under which the study findings are discussed.

On objective one that sought to establish the extent to which social factors the influence male involvement in family planning among the study population, the findings can be summarized in terms of the sub-themes including the influence of gender, religion, spousal communication and knowledge.

In regards to influence of gender roles on male involvement in family planning initiatives among the study population, the study found that even though the community is patriarchal, a majority of men (66.7%) believed that men should concern themselves with family planning. However, the study indicated that even though men should concern themselves with issues of FP, they should not have decisional role in the use of FP (2.8%) but that the choice should be made jointly by both the woman and the man (72.5%). This shows that FP initiatives should be organized to target both men and women to achieve sustainable impact.
In regards to the influence of religion on male involvement in family planning initiatives among study population, the study revealed that religion had a strong influence on male involvement in family planning initiatives among the study population. A majority of respondents, (69.7%) said that their religious teachings were against the practice of family planning. However, 66.1% of the respondents indicated that FP choices should personal.

In regards to the influence of spousal communication on male involvement in family planning initiatives among the study population, the study found that spousal communication was fundamental in the success of FP initiatives especially adoption and continuation. The study found that 79.6% of the respondents agreed that discussing family planning with their spouses and partners changed their opinions and made them look at FP positively.

Finally, in regards to the influence of knowledge on male involvement in family planning initiatives among the study population, the study found that the more knowledge a man had on FP, the higher the possibility that he would be involved in the same. For example, the study revealed that a total of 87.7% of the respondents agreed or strongly agreed that when a man has knowledge on FP, they will be able to support their sexual partner in FP choices as well as make informed decisions on FP related issues themselves.

On the second objective which was to determine the extent to which strategic factors influence male involvement in family planning initiatives among the study population, the study found out as follows.

In regards to influence of project design on male involvement in family planning initiatives among the study population, the study found that majority of men (50.3%) had never participated in any activity for designing an FP project. This finding shows that
most men who desire to be involved in FP initiatives had no such opportunity because they were never invited.

In regards to the influence of FP methods on male involvement in FP initiatives among the study population, 58.5% indicated that they had used in the last 6 months, with 100% of these being condoms. This shows that men have no option for another form of FP other than the male condoms. Even though 16.1% desired to use other methods, such methods were neither available nor affordable. The respondents felt that even though they may consider using vasectomy, such method did not give them a chance for having children in future, therefore they would think twice before undergoing the procedure.

On objective three, which sought to assess the extent to which economic factors influenced male involvement in family planning initiatives among the study population, the study found a correlation between economic factors namely income and unmet needs to influence male involvement in family planning initiatives.

In regard to influence of income on male involvement in family planning initiatives among the study population, the study also found that income strongly influenced male involvement in family planning. Of those who responded to this question 50.3% indicated that even though they would want to use condoms every time they wanted to have protected sex, they were unable to afford to buy condoms every such time. The study further found that a majority (62.1%) who are unable to buy the condoms would rely on the effectiveness of the FP method their partners are using. This shows that in a situation where the partner’s method is not effective, then men who would desire to practice family planning will not meet this objective.

In regards to influence of unmet need for family planning on male involvement in family planning, the study found that the unmet need for FP influenced the involvement
of men in FP initiatives. The study found that vasectomy was highly inaccessible with only 0.3% of the respondents indicating that they had access to such services, 12.8% desired to use this service but had no access to them. Further, the study found that a majority (71.4%) of the respondents had access to condoms while 87.5% desired to use condoms but they were unable to access them due to various reasons. These findings show that there is unmet need for FP services targeting men. Therefore, in the absence of these services, men cannot actively be involved in FP initiatives.

On the fourth objective that sought to examine the extent to which cultural factors influenced male involvement in family planning initiatives among the study population, the study finds can be summarized as follows:

In regards to influence of perception on male involvement in family planning initiatives among the study population, the study found that perception influenced male involvement in family planning at different levels and in different ways. For instance, the study found that a significant number of men (45.4%) considered vasectomy as castration that would interfere with the sexual functioning of a man. In addition, 35.5% agreed or strongly agreed that condom use reduces sexual pleasure in men, whereas 25.8% believed that women who practice FB have a likelihood of being promiscuous. These findings show that there exist different perceptions about certain aspects of FP among the study population. These perceptions influence how men involve themselves in family planning. Men who believe that FP can make women promiscuous would disallow their wives from using any form of FP and those who feel that condoms reduce sexual pleasure or that vasectomy interferes with sexual functioning of a man would not use such services, thus would not be involved in any FP initiative both at public and private levels.
In regards to influence of fertility preferences on male involvement in family planning, the study found that 70.2% of the respondents preferred 3 and above children, where as only 29.8% preferred to have 2 children below. Of those who prefer 3 and above children, 19.6% of them prefer 6 children and above. This shows that the uptake of FP services for men who have children below three would be very low.

5.3 Conclusions

From the finds of the study, several conclusions can be made as presented herein.

One, the study concluded that social factors such as religion, gender roles, knowledge on FP and spousal communication of FP significantly influenced male involvement in family planning. These factors influenced the use and continuation of FP, support of partner in decision making as well as participation in public FP initiatives. However, it was also concluded that personal choice would over shadow religious position on adoption of family planning services.

Two, the study also concluded that strategic factors such as project design practices and existing FP method are some of the strategic factors that significantly influence male involvement in family planning. The study concluded that most projects are designed without including man and are mostly targeting women. Further, the study concluded that men have limited access and choices to available FP methods with only male condom being an option. Vasectomy is very far beyond the rich of the people due to its cost and the low information available on the method.

Three, the study concluded that economic factors that influence male involvement in family planning initiatives include income and unmet need for FP. The study concluded that the inability of a man to regularly purchase male condoms any time they wanted to have protected sex negatively affected the use of such items. It was also concluded that
unmet needs for FP among the men in the study area affected their ability to use such services.

Four, the study concluded that, there is significant association between male involvement and the cultural factors such as perception and fertility reference. In this light, the study concluded that existing negative perceptions and myths surrounding various methods of FP discourage men from encouraging their use. The study concluded that there exist a lot of negative perceptions regarding perceived side effects of FP that results in men not wanting themselves of their partners to get involved in FP. Further, the study concluded that most men would not get involved in FP for limiting or spacing their children because they desired more 3 and above children.
5.4 Contribution to the Body of Knowledge

Table 5.1: Study Contribution to the Body of Knowledge

<table>
<thead>
<tr>
<th>Objective</th>
<th>Contribution to the Body of Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>To establish the extent to which social factors influence male involvement in family planning initiatives in Kakamega East Sub County of Kakamega County.</td>
<td>The study supports the argument that social factors such as religion, knowledge, spousal communication and gender are crucial considerations in the planning and implementation of FP initiatives.</td>
</tr>
<tr>
<td>To determine the extent to which strategic factors influence male involvement in family planning initiatives in Kakamega East Sub County of Kakamega County.</td>
<td>The findings of the study supports the existing belief that public participation in projects is key and that specific initiatives should be tailored to the needs of the target population.</td>
</tr>
<tr>
<td>To assess the extent to which economic factors influence male involvement in family planning initiatives in Kakamega East Sub County of Kakamega County.</td>
<td>The study recognizes the important role income and unmet need plays in male involvement in FP initiatives. Considering the economic status and the need level of the target group can greatly contribute to success or failure of the initiative.</td>
</tr>
<tr>
<td>To examine the extent to which cultural factors influence male involvement in family planning initiatives in Kakamega East Sub County of Kakamega County.</td>
<td>Culture influences human behavior. This study contributes to the existing knowledge that before an FP program, project or activity is undertaken, the designers of such project must consider cultural beliefs and practices such as perceptions and fertility preferences.</td>
</tr>
</tbody>
</table>
5.5 Recommendations

From the findings of the study, it was recommended that both the public and private FP initiatives in Kakamega East Sub County should be designed to focus on awareness creation to address the knowledge gaps and demystify the existing myths and perception about family planning. The benefits of FP and all the relevant information on the methods should be actively taught to the community. This will ensure that men are informed on FP related issues so that they can be actively involved in all FP initiatives. Progressively, this will lead to more uptake of FP services as well as increase the sustainability of the impacts of such initiatives.

The study recommended that partners and stakeholders who are designing FP programs, projects and activities in the area should ensure to involve men in the entire project cycle to enable them own such initiatives and not see them as ‘outsider’ initiatives. This will ensure that they support such services and have their opinions, contributions and ideas incorporated. This is considered project planning and management practice that carries with it sustainable results. In a patriarchal community like in the study population where men are dominant in decision-making, encouraging spousal communication and involving men in family planning decision-making is important in enhancing male involvement.

From the study, it can be recommended that cheaper forms of condoms be distributed at convenient places that can be access by men who desire them. In addition, vasectomy services should be made accessible by conducting community outreach services and offering services to those who cannot afford them. Projects that promote adoption of vasectomy however should target men who are 46 and above and not among the younger men who still want to have children.
Since a majority of men who cannot afford male condoms rely on FP methods used by their partners, the study recommended that there should be initiatives aimed at increasing access and affordability of FP for women. This will work to supplement the efforts male partners would be putting in regards to family planning.

The researcher finally recommends that if programs, projects and activities are to increase use of family planning methods, attention must be focused explicitly on nonusers who are in need of contraceptive services. Hence, analyzing respondents’ future intention of using family planning and identifying reasons for not intending to use in the future have important implications for programs.

5.6 Suggestions for Further Research

From the study a number of men cited that condom reduces the sexual pleasure among men. This study recommends that a study be conducted to ascertain whether this is just a perception or it is a fact.

The same study can be replicated in other sub counties in Kakamega county for comparison purposes and to generate a report that can be used in a county-wide FP initiative.
REFERENCES


Dewi, V. (2009). Factors that influence male participation in family planning and reproductive health in Indonesia (master's thesis). The Flinders University of South Australia.


APPENDICES

APPENDIX I: HOUSEHOLD AND POPULATION DATA

Projected households sizes by administrative units in Kakamega East Sub County based on the 2009 Household Survey and Population Census (KNBS, 2010).

<table>
<thead>
<tr>
<th>Location</th>
<th>Sub-location</th>
<th>Total Population</th>
<th># of Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ilesi</td>
<td>Mukhonje</td>
<td>1865</td>
<td>2209</td>
</tr>
<tr>
<td></td>
<td>Malimili</td>
<td>1034</td>
<td>1181</td>
</tr>
<tr>
<td></td>
<td>Mugomari</td>
<td>6580</td>
<td>1400</td>
</tr>
<tr>
<td>Murhanda</td>
<td>Mukulusu</td>
<td>9485</td>
<td>2018</td>
</tr>
<tr>
<td></td>
<td>Shisembe</td>
<td>5968</td>
<td>1270</td>
</tr>
<tr>
<td></td>
<td>Shiswa</td>
<td>11860</td>
<td>2523</td>
</tr>
<tr>
<td></td>
<td>Itenyi</td>
<td>5489</td>
<td>1168</td>
</tr>
<tr>
<td>Khayega</td>
<td>Lugose</td>
<td>7050</td>
<td>1500</td>
</tr>
<tr>
<td></td>
<td>Sitochi</td>
<td>9574</td>
<td>2037</td>
</tr>
<tr>
<td></td>
<td>Museno</td>
<td>6857</td>
<td>1459</td>
</tr>
<tr>
<td></td>
<td>Shirulu</td>
<td>5514</td>
<td>1173</td>
</tr>
<tr>
<td></td>
<td>Shidodo</td>
<td>12529</td>
<td>2666</td>
</tr>
<tr>
<td>Shibuye</td>
<td>Virhembe</td>
<td>11156</td>
<td>2374</td>
</tr>
<tr>
<td></td>
<td>Mukango</td>
<td>7441</td>
<td>1583</td>
</tr>
<tr>
<td></td>
<td>Shingodo</td>
<td>13957</td>
<td>2778</td>
</tr>
<tr>
<td></td>
<td>Shiasaba</td>
<td>8408</td>
<td>1789</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>137800</strong></td>
<td><strong>29128</strong></td>
</tr>
</tbody>
</table>
APPENDIX 2: QUESTIONNAIRE FOR STUDY RESPONDENTS

Dear Participant,

Hello my name is Peter Oduk, a student at University of Nairobi undertaking a degree of Master of Arts in Project Planning and Management. I am conducting a research on ‘Factors Influencing Male Involvement In Family Planning Initiatives In Kakamega East Sub County’. You have been sampled to participate in this study by responding to the following questionnaire items. Kindly provide us with honest responses. Before you participate, the informed consent form will be read to after which if you agree to the contents, we will continue with the interview. This questionnaire will take us approximately 40 minutes to complete. Whatever information you provide will be kept confidential and will not be shared with anyone other than members of my study team. Thank you.

Participation in this survey is voluntary, and if we should come to any question you don't want to answer, just let me know and I will go on to the next question; or you can stop the interview at any time. However, I hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the research?

May I begin the interview now?

Signature of interviewer:  
Date:

RESPONDENT AGREES TO BE INTERVIEWED [   ] 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED [   ] 2 END

SECTION 1: DEMOGRAPHIC CHARACTERISTICS

1. What is your age?
   18-25 [ ] 26-35 [ ] 36-45 [ ] 46-55 [ ]
2. What is your marital status?
   Married [ ] Single [ ]
3. What is your highest level of education attainment?
   Primary [ ] Secondary [ ] Tertiary College [ ] University [ ] None [ ]
4. What is your average monthly income in Kenya Shillings?
   0 – 5000 [ ] 5001 – 10,000 [ ] 10,001 – 20,000 [ ] Above 20,000 [ ]
5. What is your religious affiliation?
   Catholic [ ] Protestant [ ] Muslim [ ] None [ ] Other (specify)--------

SECTION 2: SOCIAL FACTORS INFLUENCING MALE INVOLVEMENT IN FP

A. RELIGION
6. Based on your religion do you accept the practice of family planning?
   Yes [ ] No [ ]
7. Please provide your reasons for 23 above
   My church teaches [ ] Practice of FP equals killing [ ] FP is a personal choice [ ] Other (specify)---

B. KNOWLEDGE ON FP
8. Which ways or methods of FP have you heard about?
   IMPLANTS Yes [ ] No [ ] MALE STERILIZATION Yes [ ] No [ ]
   PILL Yes [ ] No [ ] FEMALE STERILIZATION Yes [ ] No [ ]
   INJECTABLES Yes [ ] No [ ] LAM Yes [ ] No [ ]
MALE CONDOM  Yes [ ] No [ ]  FEMALE CONDOM Yes [ ] No [ ]
IUD Yes [ ] No [ ]
WITHDRAWAL Yes [ ] No [ ]  EMERGENCY CONTRA. Yes [ ] No [ ]

9. For the methods you know of, where was your source of information
Media (radio, TV, internet) [ ]  Spouse [ ]  Children [ ]  Seminar/training [ ]  Other

10. What is your level of agreement with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of FP determines the choice of method you can use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of FP influences how you handle side effects of FP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge is does not influence a man’s involvement in FP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge enable a man to support a partner on FP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. SPOUSAL COMMUNICATION
11. How often have you discussed family planning with your partners?
   Regularly [ ]  Occasionally [ ]  Never [ ]  (if Never, go to question 24).
12. Did the discussion of FP with your partner influence your involvement in FP?
   Yes [ ]  No [ ]
13. What are some of the reasons for you not discussing FP with your spouse?
   FP is a woman’s issue [ ]  Fear of being ridiculed [ ]
   I do not approve of FP [ ]  I have no information on FP [ ]
   Other (specify—

D. GENDER ROLES
14. Should a man concern himself with issues of FP?
   Yes [ ]  No [ ]
   If yes give reasons

15. Who should make decisions on use of FP in the family?
   Man [ ]  Woman [ ]  Both [ ]  Don’t know [ ]

SECTION 3: STRATEGIC FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING INITIATIVES

A. PROJECT DESIGN
16. Have you ever participated/involved in design/planning of any FP activity in this area?
   Yes [ ]  No [ ]  (if Yes go to 8)
17. Why haven’t you participated in 9 above?
   Lack of knowledge [ ]  Was not invited [ ]  It was for Women [ ]  Didn’t know about it [ ]

B. FAMILY PLANNING METHOD
18. Have you used any modern family planning method in the last six months?
   Yes [ ]  No [ ]  (If No. go to 11)
19. Which method are your currently using?
   Condoms  Vasectomy
20. Why have you chosen to use this method?
   Cost [ ]  Convenience [ ]  Well known [ ]  Other (specify———)
21. Can you consider undergoing vasectomy?
   Yes [ ]  No [ ]
22. Why would you not consider undergoing vasectomy?
   - It is costly [ ]
   - I will not be able to have other children [ ]
   - My wife will be promiscuous [ ]
   - I don’t know where it is done [ ]
   - I am afraid of the procedure [ ]
   - I don’t have information about it [ ]
   - Other (specify)

SECTION 4: ECONOMIC FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING

A. UNMET NEED FOR FP
23. Which Family planning method do you have access to?
   - Condom [ ]
   - Vasectomy [ ]
   - None [ ]

24. Which one would you want to use but have no access to?
   - Condom [ ]
   - Vasectomy [ ]

B. INCOME
25. Are you able to buy condom for use every time you are having sex?
   - Yes [ ]
   - No [ ]

26. If you were unable to purchase/pay for the method, what would you do instead?
   - Stop using FP [ ]
   - Resort to natural method [ ]
   - Discontinue sex [ ]
   - Rely on the method my partners is using [ ].

SECTION 5: CULTURAL FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING.

A. PERCEPTION
27. What is your level of agreement with the following statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning encourages promiscuity in women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use reduces sexual pleasure/virility in men</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men involved in manual labour should not go for Vasectomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning makes a woman cold in bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasectomy is synonymous to castration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending FP is a woman’s issue and not a man’s.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. FERTILITY PREFERENCES
28. How many children would you prefer?
   - None [ ]
   - 1-2 [ ]
   - 3-5 [ ]
   - 6 – Above [ ]

29. Would you use FP for limiting the number of children you want to have?
   - Yes [ ]
   - No [ ]

30. Would you use FP for spacing the birth of children you want to have?
   - Yes [ ]
   - No [ ]

Thank you for accepting to participate in this study.
THIS IS TO CERTIFY THAT:

MR. PETER OMOGI ODUK
of UNIVERSITY OF NAIROBI, 3394-40100
Kisumu, has been permitted to conduct research in Kakamega County

on the topic: FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING INITIATIVES IN KAKAMEGA EAST SUB COUNTY, KAKAMEGA COUNTY,

for the period ending:
28th October, 2016

Applicant's Signature

Director General
National Commission for Science, Technology & Innovation

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do so will lead to the cancellation of your permit.
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two (2) hard copies and one (1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.

RESEARCH CLEARANCE PERMIT

Serial No. 6983

CONDITIONS: see back page