

**FACTORS INFLUENCING MALE PARTICIPATION IN FAMILY
PLANNING: A CASE OF KUTUS TOWNSHIP IN KIRINYAGA
COUNTY IN KENYA**

BY

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DECLARATION

This research project report is my original work and has not been presented for any award in the University of Nairobi or any other University.

Signed

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

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DEDICATION

To my late Dad (John Muiga Kahindo) I wish you lived to see this day. To loving John and Prudence and Harmony for the encouragement, understanding, financial and moral support accorded during my study. To my dear mother for her constant prayers and to my family members: mum Hannah, Rose, Martha, Juliet, Gerald, Isaac, Jackline, Daniel, Susan and Allan for giving me the encouragement to be able to sail through my coursework regardless of the tight schedule of not only taking care of my siblings but also measuring to standards in my place of work and Academic assignments.

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LIST OF ABBREVIATIONS AND ACRONYMS

CPR	Contraceptive Prevalence Rate
DOW	Doctors of the World
FGD	Focused Discussion Group
FP	Family planning
ICPD	International Conference on Population and Development
KDHS	Kenya Demographic and Health Survey
KII	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
MCH	Maternal and Child Health
MOFP	Ministry of Finance and Planning
NCAPD	National Coordinating Agency for Population and Development
SPSS	Statistical Package for Social Studies
STDs	Sexually Transmitted Diseases.
UNFPA	United Nations FP Agency
WHO	World Health Organization

ABSTRACT

The purpose of this study was to analyse the factors that influence male participation in the study area was Kirinyaga Central District. The objectives of the study were to find out the extent to which available male FP methods, FP cost, male perception and traditional belief influence male participation in FP. The study used a descriptive Survey descriptive decision which helps to gather information about these factors. The target population was sexually active men and women above 20 years of age of Kirinyaga central district. A simple size of 200 respondents which composed men, women and health workers was selected using stratified random sampling technique. Questionnaire and interview guide were used to collect the required data. A pilot study was carried out with twenty respondents to ensure the validity and reliability of the research instrument. The questionnaires and interview report were collected and the data analysed and a descriptive statistic such as a mean and percentages were generated in form of tables. The study findings reveal that the available FP methods do influence in male involvement in FP to some extent. 70% of the respondent agreed that available male method lacked diversity and 57% of women were of the opinion that the methods were inadequate. The research findings did demonstrate the element of cost as a barrier to the uptake of FP among men. 77% of the respondents were of the opinion that the available family planning methods for men are too expensive and unaffordable. 82% of the respondent held the opinion that men who use family planning are disrespected in the society. There was adequate awareness of FP and its importance both among men and women. Range of family planning methods available to men is limited, and this as a result inhibits men's capacity to participate in fertility regulation. Greene (2005). There however seem to be higher awareness of female FP methods compared to the male FP methods. This raises the issue of diversity for FP methods for men in influencing uptake of the same. All these men who stated that they use FP methods were using the male condom as opposed to women who were using varied methods such as the pill, injectable and implants. It can be concluded that the key barrier to uptake of FP by men was mere attitude or negative perceptions towards FP by men and the belief that FP as a woman's affair because they are the ones who get pregnant. To this effect, it was noted that most male respondents said their spouses are on FP while most women respondents stated that their spouses were not using any FP methods. Some of the perceptions that lead to low uptake of FP among men are the perception that male FP methods are rare and not convenient/effective. Male involvement in FP has a positive impact in the general wellbeing of the family and hence the following measures should be taken in order to increase participation: Kenyan government and the WHO should strive to introduce new male FP methods in order to increase diversity. Enhancement of knowledge and awareness on the need of male participation .

CHAPTER ONE

INTRODUCTION

1.1. Background of the study

FP is getting a child by choice and not by a mere chance. It involves a conscious decision on size of the family and the spacing between the children. FP programs are an essential part of services to reduce maternal and child mortality rates, because they enable women to postpone, space or limit pregnancy. Kenya's population has risen rapidly over the past four years, with the proportion of youth also increasing. In 2009, 43% of Kenya's population was under age 15 years – higher than for Africa as a whole. Early age at first marriage and birth, and low contraceptive use, are among factors that have contributed to Kenya's youthful population.

The framework, developed by the WHO Regional Office for Africa, in collaboration with its partners calls for increased efforts to advocate the recognition of the pivotal role of FP in achieving health and development objectives at all levels, as targeted by MDGs 4, 5 and 6. Although unsafe abortion was preventable, it continues to pose undue risk to the lives of African women. Unsafe abortions account for about 14% of maternal deaths on the continent. Thirty-one out of 1000 African women aged 15–45 years are estimated to experience unsafe abortion annually. The Eastern and Middle African countries are reported to have the highest rates of unsafe abortion, 36 per 1000, whilst the lowest rates are in Southern Africa (9 per 1000). roughly 51% of all maternal deaths involve African women aged from 15 to 29 years UNDP (2009).

However, traditional beliefs, religious barriers and lack of male involvement have weakened FP interventions WHO, (2012). Kenya was working towards increasing the overall CPR among married women to 56% by 2015, among adolescents (15-19 years) from 4% in 1998 to 8% and among youth aged 20-24 years from 19.9% to 40% by 2015. One of the implementing strategies laid out in the National Reproductive Health Strategy 2009-2015, In the 1990s, many women's health programs began to acknowledge that FP must be viewed in the broader context of reproductive health. The program of action adopted by the International Conference on Population and Development (ICPD) held in Cairo 1994 noted that special efforts ought to be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including FP; pre-natal, maternal and child health; prevention of Sexually Transmitted

Diseases (STDs); and prevention of unwanted and high-risk pregnancies Levy, (2008). The Beijing world women conference in 1995 also re-enforced this message when it recognized the importance of “shared responsibility between men and women in all issues of related to reproductive health”.

Men's involvement in decisions about sex, contraception and childrearing strongly influences sexual and contraceptive behaviour, significantly strengthens and reduces discord in relationships, and reinforces a man's responsibility for the children he fathers. Few studies, though, have investigated men's perceptions of their roles and responsibilities regarding decisions about sex, contraception and the raising of children. Furthermore, only recently has such research been identified as being important. High levels of non-marital childbearing, growing concern about the spread of AIDS and other sexually transmitted diseases (STDs) and the concomitant increase in the prophylactic use of condoms has led developers of social policy to include men in efforts to prevent pregnancy and STDs. However, most investigations of men's perceptions about their roles and responsibilities have targeted adolescents and other groups of young, unmarried males. Thus, we have little understanding of how married or older men perceive their roles in these decisions.

Men in the developing world, Kenya included, are often the primary decision-makers about family size and use of FP Nzioki, (2001). A considerable discordance between spouses on questions of FP and desired family size has also been identified; in some developing countries, levels of communication on these topics are low. Inter-spousal communication was related to contraceptive decision-making and positively affects contraceptive uptake and continued use, whereas failure to communicate reproductive intentions limits couples' effective and sustained contraceptive use Oyiediran, (2002).

Male involvement is not only restricted to the uptake of male FP methods but also includes the number of men who encourage and support their partners and their peers to use FP. It also involves the influencing of policy environment to be more conducive to development of male related programs. Therefore, male involvement should be understood as all the organizational activities whose main aim was to increase the prevalence of contraceptive for either gender (Green and Chens, 2003). The disadvantage of the female orientation of FP program was that it precludes a proper coverage of reproductive health which encompasses some issues such as sexuality, STDs, HIV/AIDS, and infertility that call for men and women as partners (Becker 1996,). Without the active participation of husbands in these activities, the goals for improving reproductive health among women become difficult to achieve. Furthermore, the female focus of the FP programs fails to recognize the

dominant role of males in the household in making decisions about the family's reproductive health. Schuler, Hashemi, and Jenkins (1995,) have found that women in Bangladesh are dependent on their husband's decisions in FP and reproductive health. Sometimes, husbands do not allow their wives to use contraceptives. Divorce and abandonment are the punishment for those wives who secretly use contraceptives without their husband's permission. A similar situation exists in Indonesia. A husband's approval was important because the decisions about matters that deal with family life are mostly made by the husband Joesoef, Baughman & Utomo (1988,).

The benefit of involving men in reproductive health activities could also improve women's participation in FP. Studies in Brazil, Indonesia, and elsewhere (Becker & Robinson 1998, p. 276) have found that there was a growing number of female clients who have receive their right for using contraception since their husbands have received FP information, and attended couples' counseling about sexuality. Further, a study in Nigeria Oyediran et al. (2002,) shows that there was significant improvement in men's contraceptive prevalence, especially among educated, young, urban resident, for both men and women, who receive FP counseling.

Failure to involve men in the FP programs in a patriarchal society like Kenya can have serious consequences even if women are motivated to practice contraception because of opposition from the spouse. This opposition accounted for 23% of the unmet FP needs during the Kenya demographic and health survey KNBS and ICF Macro, (2010). This study was therefore aimed at establishing the factors influencing male involvement in FP in Kerugoya district hospital.

1.2. Statement of the problem

FP programs are an essential part of services to reduce maternal and child mortality rates, because they enable women to postpone, space or limit pregnancy. Kenya's population has risen rapidly over the past four years, The Kenya population growth rate was now estimated at 2.7% (as of 2010), resulting in an estimate of a total population 41 million in 2011 Kenya National Bureau of Statistics (2011).

Male involvement in discussions about FP was essential for a number of socio-cultural, economic reasons. Men as partners need to be engaged in the practice of FP- as users of male methods of contraception, and as facilitators for the partner's access to services. It was encouraging to note from KDHS 2008/9 that 77 percent of men feel strongly that decisions on how many children to have should be made together with their wives. Every

day, 1,600 women and more than 10,000 newborns die from preventable complications during pregnancy and childbirth. Almost 99% of these maternal and 90% of neonatal deaths occur in the developing countries. As the first pillar of safe motherhood and an essential component of primary health care, FP plays a major role in reducing maternal and newborn morbidity and mortality. FP enhances efforts to improve family health.

In Kerugoya district hospital more women seek FP services than their male counterparts. For the last six months in the FP clinic, on average 42 women per day seek services compared 2 male per month who mostly are referred from the comprehensive care clinic or gynaecologist clinic as part of management of other conditions like HIV and gynaecological problems MCH Data, (2013)

The Kenya Demographic and Health Survey report, (2008) reported that 97% of all men and 95% of all women know at least one method of contraception, which means men are more knowledgeable about FP issues than women. It was evident from this study that high knowledge on contraception was not matched with the high contraceptive use. Therefore the study seeks to determine the factors influencing the participation.

1.3. Purpose of the Study

To determine the factors influencing male participation in FP a case of Kutus township in Kenya

1.4. Research Objectives

The research objectives of this study were:

1. To assess the extent to which available male FP methods influence men's participation in FP.
2. To establish if cost of FP influence male participation in FP
3. To determine the extent to which male perception of FP influence their participation in FP.
4. To investigate whether traditional beliefs influences male participation in FP

1.5. The Research Questions

The research questions of this study were:

1. To what extent do available male FP methods influence men's participation in FP?
2. To what degree does cost of FP influence men's participation in FP?
3. How does male perception of FP influence their participation in FP?
4. To what magnitude does traditional beliefs influence male participation in FP?

1.6. Significance of the study

A clear understanding of the factors influencing male participation was important for the counties and country's population policy and FP programs. Other beneficiaries are the stake holders in the FP programs such as male, females and children due to improved FP strategies and policies. It will provide policy makers, planners and program managers with the information required for strengthening FP programs.

1.7. Limitations of the study

According to Best and Kahn (1998), limitations are conditions beyond the control of the Researcher that may place restrictions on the conclusions of the study and their application to other situations. Time and resources were the limitation since the researcher did not seek funding from external source, she used personal resources. The data that was collected was quite confidential but the researcher was in need of it to draw conclusions. Thus, in this particular case there was no way the researcher would have avoided handling sensitive data. However, the collected data was only used for intended purpose and the researcher observed research ethics throughout the research.

1.8. Delimitation of the Study

The study was limited to sexually active men and women in Kirinyaga central district aged above 20 years and health workers in the government health facilities within the district who voluntarily consented to the study.

1.9. Basic Assumptions of the Study

It was assumed that the sample represented the population and respondents answered the questions correctly and truthfully. It was also assumed that the sample size chosen was adequate to enable the researcher draw a valid conclusion about the population.

1.10. Definition of Terms

Cost The monetary expenditure on FP.

FP: This is the planning of when to have children, and the use of birth control and other techniques to implement such plans. It was the voluntary planning and action taken by individuals to prevent, delay or achieve a pregnancy.

Perception: Perception is our sensory experience of the world around us and involves both the recognition of environmental stimuli and actions in response to these stimuli.

Participation: The fact of taking part, as in some action or attempt: participation in a celebration.

Tradition belief: A belief or behaviour passed down within a group or society with symbolic meaning or special significance with origins in the past.

Method: A means or manner of procedure, especially a regular and systematic way of accomplishing something:

1.11 Organization of the study

This research paper is organised in five chapters:

Chapter One introduction covering background of the study Statement of the problem, research objectives, research questions, justification of the study, limitation and delimitation of the study, significance of the study, assumption of the study and definition of significant terms ,

Chapter Two is about literature review organised in themes: lack of diverse methods, cost of FP, men perception and traditional beliefs, and the chapter analysis and critiques literature related to the study from global regional and local perspective. The chapter concludes with a conceptual frame work which is a brief explanation of the relationship between the variables identified in the statement of the problem, the research objective and research questions.

Chapter three presents the methodology used in this study: study design, sampling procedure, data collection, validity and reliability of research instrument, measurement of variables, methods of data analysis and ethical issues and operationalization of variables

Chapter four presents the finding, data analysis and implication of the survey based on the four objectives of the study. The data was presented in form of tables which showed frequencies and percentages of the variables.

Chapter five is a summary of the findings; an in-depth discussion of the main finding is given. Recommendations based on this study are also provided in this chapter.

The study concludes by appendices with a letter of transmittal, questionnaire for the clients and interview guide for the health workers.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter critically analyses by objectives, some of the factors that influence men's involvement in FP. The literature outlines what has been done by others in this area and then identifies some knowledge gaps as far as male involvement in FP was concerned. It utilizes the literature from these previous studies to generate theoretical and operational frameworks that forms the basis of this study.

2.2. The level of Male participation in FP

FP has been an age long issue, recognized for its importance in improving the health of the family. However, Africa has lagged behind other world regions in the adoption and expansion of FP. Comparing this with the world, the situation in countries on four (4) continents showed that more than sixty (60%) of men expressed willingness to use a new male contraceptive. These men would like to relieve their partners of some of the contraceptive burden in their relationship (Heinemann, 2005). Given the crucial role that African men play in family decisions, their support and involvement is essential for FP to become more widespread. Traditionally, FP and reproductive health services have been female focused. In the past, the focus made sense, since most of FP methods are female dependent, and women are disproportionately affected by negative consequences of unintended pregnancy and sexually transmitted infections (STI). However, since the onset of the AIDS epidemic, reproductive health professionals have recognized the important role that supportive male partners can play in improving the use of contraception and reducing the risk of unintended pregnancies and the spread of STIs. Today, the major focus is male reproductive health is on males' utilization of FP services and using male methods such as condoms: the one method of FP that if used consistently and correctly can greatly reduce the risk of unintended pregnancy and STIs including HIV (Heinemann, 2005).

Men are Important Supporters and Important Clients

To health care providers, men are important for two reasons: First, they influence women. Some men care about their partner's reproductive health and support them. Others stand in their way or make decisions for them. Thus, men's attitudes can determine whether women can practice healthy behaviours. In some circumstances, such as avoiding HIV

infection or getting help quickly in an obstetric emergency, a man's actions can determine whether a woman lives or dies.

Men are also important as clients. Major FP methods—male condoms and vasectomy are used by men. Men also have their own sexual and reproductive health needs and concerns in particular regarding sexually transmitted infections (STIs)—which deserve the attention of the health care system and providers.

In order to improve a country's reproductive health, the ICPD UN (1995,) recommends that the FP program of that country should have a specific purpose. It would facilitate couples or individuals to make their own decisions, be responsible for deciding on the number of children they would like to have, and the intervals they would want to have between each child. Furthermore, the FP program must provide the population with safe and effective contraceptives and allow the opportunity for making an informed choice about the use of their chosen contraceptive.

FP programs have been predominantly directed towards women perhaps because women bear children and there are more contraceptives for women than for men. However, it has been found in many developing countries that the decision to use or not to use contraceptives, and the choice of a particular contraceptive method, very often depends on the approval of the husband. Therefore, the FP program must involve men (as well as women) to satisfy a couple's sexual and reproductive needs. Men should also be involved in encouraging their wives to utilize the available reproductive health care facilities Sharma (2003). The importance of realizing men's role in reproductive health decisions must be considered by the policy makers of FP programs. In this context, the FP program must build awareness among men about the importance of their involvement in the process of contraceptive use by their wives or by themselves. In a patriarchal society which still prevails in most countries, husbands make the most of the important decisions for their families. It was necessary to have effective communication between husband and wife in order to ensure equal roles in matters of reproductive health. Such communication can also bring many advantages for the growth of men's consideration to participate in FP Population Council (1998).

Research has revealed significant improvements in changing the focus of FP to men. For instance, in Nigeria Oyediran (2002), married men are documented as having knowledge about contraceptive methods and using them. They use contraception to avoid and delay pregnancies of their wives. Moreover, men's participation observed in this study was not only limited to the use of male contraceptive methods, but also to supporting their wives in using

female contraceptive methods. However, men's participation in FP was not restricted in scope only to using male methods of FP such as condoms or vasectomy procedures. In terms of the bigger picture, men's involvement consists of accommodating their behavior so as to sharing the responsibility in addressing the reproductive health needs with their wives, including female contraceptive use Population council (1998). Then, an awareness of participating in FP program has been growing among men. In this context, the UNFPA 1995 cited in Khan & Patel (1997) has compiled a list of the importance of men's involvement in FP. In this list, men's roles contain more complex benefits that can be achieved by maximizing men's role in FP. The motivations for developing men's participation in FP are: Preventing the spread of the HIV/AIDS epidemic by promoting condoms as dual protection (for contraceptive and HIV / AIDS protections) Men's attitudes toward FP have shown positive improvement than FP policy makers had previously thought .There are benefits to be had from men's supportive attitudes for the use of female contraception .The low cost men's improvement program can be achieved by focusing on a men's program for male contraceptive methods.

There are various roles that men can play in the success of a FP program. Firstly, men are involved as managers and decision makers in FP in their family's life. Due to an imbalance in the proportion of men and women who serve as FP providers and policy makers, Helzner (1996) recognizes this issue as reflecting a gender bias in society. A large number of women work in the lower levels of FP institutions as nurses, counselors or FP field workers, but very few women hold high positions such as physicians, administrators or directors. Obviously, men who are in higher positions have the advantage of making policies for the FP program. Thus, the policies that are made by men sometimes reflect their bias to maintain their dominance over women, and create inequality between the sexes. Otherwise, men who hold high positions in FP program must consider for applying more positive attitudes for the improvement of the reproductive health of families.

Secondly, men are involved as clients and motivators to increase contraceptive prevalence. Helzner (1996) mentioned that men's active participation in FP could raise the use of male contraceptive methods (condom and vasectomy), or male dependent traditional methods (withdrawal and abstinence). Men also could support their wives in using female contraceptive methods (IUD, pill, implant, and injections).

Thirdly, men are involved as agents of change for gender equality. Helzner (1996) argues that it was better to involve the husband and wife as equal partners than just encourage

men to participate in FP program. This spousal involvement can reduce the general stereotypical gap between the sexes. Addressing this issue, the FP program must promote equal role models in which husbands and wives share the responsibility in improving their families' reproductive health. Therefore, this program should encourage effective inter-spousal communication.

2.3. Available Male methods and male participation in FP

DHS data show that increased use of modern methods of FP drove the overall increase in contraceptive prevalence rates between 1989 and 2008. For example, use of modern methods among married women ages 15–49 increased from 32 percent in 2003 to 39 percent in 2008, while use of traditional methods actually decreased from 8 percent to 6 per cent during these years. Injectable have been the most

Despite the fact that men play an important role in reproductive health, studies have shown that there are certain hindrances to male utilization of FP service. Range of FP methods available to men was limited, and this as a result inhibits men's capacity to participate in fertility regulation. Greene (1995). The inadequacy of male method of contraceptives has caused considerable media attention surrounding a recent breakthrough, in the development of a male birth-control pill. The fact of the issue was that, production of a new male method of contraceptive was still about 5-10 years away with some technical hurdles to overcome (Duorsky, 2008). Men would use a hormonal male contraceptive, delivered by injection and/or implant; this would be less intrusive method, likely that men were show more interest in using FP (Heinemann et. al., 2005). Other studies have revealed that there are a lot of choices to make on FP methods for male, including the traditional methods, but because of certain beliefs coupled with inadequate knowledge of certain methods of contraception some men are against their use with reasons best known to them (Nzioka, 2000). Here, the reality was that FP services available for men are few and, besides, the facilities providing FP services are also not enough, even the few available are not male user-friendly. According to a demographic health survey done in Ilorin Nigeria, FP clinics are oriented towards women, therefore men often feel uncomfortable and unwelcome in these clinics Olawepo & Okedare, (2006).

According to a survey on approved contraceptive use, men's lack of access to the FP service was a barrier to its use. Therefore, men cannot share their responsibility on reproductive health, including FP if they cannot access the service. Most FP clinics, according to a study mainly cater for women, so men are not comfortable visiting these

clinics Population Report, (1994). This contradicts the findings of a study done in Danfa, Ghana that showed that men can easily access FP service IPPF, (1984). The study shows that men even prefer buying the condoms from existing mobile outreach clinics than buying it from drug stores. Similarly, a case study conducted in Khaochakan district in Thailand showed that majority of males knew where the FP service was available, some know about health centers, others, hospitals while some primary health care units and drug stores. Majority of the male clients had to travel for the service at less cost (En, Som-arch, & Kanittha, 2004). The real situation on the ground was that although men are aware of FP service, access and utilization was low and poor.

The disadvantage of the female orientation of FP program was that it precludes a proper coverage of reproductive health which encompasses some issues such as sexuality, STDs, HIV/AIDS, and infertility that call for men and women as partners Becker (1996). Without the active participation of husbands in these activities, the goals for improving reproductive health among women become difficult to achieve. Furthermore, the female focus of the FP programs fails to recognize the dominant role of males in the household in making decisions about the family's reproductive health. Schuler, Hashemi, and Jenkins (1995,) have found that women in Bangladesh are dependent on their husband's decisions in FP and reproductive health. Sometimes, husbands do not allow their wives to use contraceptives. Divorce and abandonment are the punishment for those wives who secretly use contraceptives without their husband's permission. A similar situation exists in Indonesia. A husband's approval was important because the decisions about matters that deal with family life are mostly made by the husband Joesoef, Baughman & Utomo (1988).

The benefit of involving men in reproductive health activities could also improve women's participation in FP. Studies in Brazil, Indonesia, and elsewhere (Becker & Robinson (1998) have found that there was a growing number of female clients who have receive their right for using contraception since their husbands have received FP information, and attended couples' counseling about sexuality. Further, a study in Nigeria (Oyediran et al. 2002, p. 509) shows that there was significant improvement in men's contraceptive prevalence, especially among educated, young, urban resident, for both men and women, who receive FP counseling.

2.4. Cost of FP and male participation in FP

According to the 2003 KDHS, 53 per cent of FP users obtained contraceptives through public facilities, while 41 per cent and 5 per cent of FP users obtained contraceptives

through private medical and other sources, respectively. Only 1 per cent of users obtained their contraceptives through community based distribution.

The study shows that men even prefer buying the condoms from existing mobile outreach clinics than buying it from drug stores. Similarly, a case study conducted in Khaochakan district in Thailand showed that majority of males knew where the FP service was available, some know about health centers, others, hospitals while some primary health care units and drug stores. Majority of the male clients had to travel for the service at less cost (En, Somarch, & Kanittha, 2004). The real situation on the ground was that although men are aware of FP service, access and utilization was low and poor.

Women in the richest wealth quintile appear to be more likely than women in the poorest wealth quintile to use long-term contraception, which was more expensive than short-term contraception and usually provided at clinics. Thus, closing this particular gap between the rich and the poor in developing countries was entail addressing women's access to contraceptives and making all methods affordable. As an example, the cost to a couple of using contraception consistently for one year (i.e. couple-year of protection) ranges from 0.1% (for intrauterine devices) to 6.7% (for male condoms) of the annual per capita household consumption expenditure (281.03 United States dollars) in Ghana, one of richest countries we studied. Clearly, with the cost per couple-year of protection being so similar for short-term and for long-term methods of contraception, and since wealth-related inequalities are greater in the use of long-term methods, simply making short-term methods more widely available or improving their distribution was not suffice to close the rich-poor gap.

2.5. Male Perceptions of FP and male participation

The Kenya Demographic and Health Survey (KDHS, 2008) reported that 97% of all men and 95% of all women know at least one method of contraception, which means men are more knowledgeable about FP issues than women. This may be due to the fact that illiteracy level among women was higher than men. Other studies have proved that although men are well informed about FP service, the same cannot be said of accessing and utilization of the service (NDHS Male Module, 2003). It has further been established that 1 in 3 men considers contraception to be a woman's issue. This was the general view of the individual but the fact was that if the men are encouraged and motivated they was show interest in utilizing the FP service in Ghana in particular and Africa as a whole. While half of the men felt that women who use contraceptive may become promiscuous, other men also perceive that although childbirth was a woman's business, husbands support was crucial on matters

concerning usage of FP service. Few men believe that men and women share equal responsibility about contraception (Gray et al., 1996).

A survey conducted in Dan Forth (1999) indicated that overwhelming reliance on female methods of contraceptives has led to the assumption on the part of many men that contraception was only for women. This again was general observation of many people but what was known in literature disagrees with the notion that women are the only people interested in FP issues. Men, normally, play a role in decision making concerning reproductive health issues including FP.

According to a survey conducted in Mpigi district in Uganda, it was revealed that, men have limited knowledge about FP, that FP service does not adequately meet the needs of men and that, spousal communication about FP issues was generally poor. (Kaida et al. 2005) Here, one can contribute to the fact that men, both adult and young have favorable knowledge and attitude related to FP but very few report the use of contraceptives.

Again, another study in the service area of the Jawaharlal institute urban Health Centre showed that most men were aware of most of the FP methods such as permanent method of sterilization (vasectomy & tubectomy), condoms, abstinence and the other contraceptive devices, even some men prefer particular methods to others (Kumahikupam, 2003). This shows that knowledge and preference play a role in the study, but not utilization of the methods. According to a study done to investigate men's knowledge, attitude and practice of FP in Enugu Nigeria, it was revealed that males have some level of knowledge about FP and modern contraceptives methods but it showed considerable opposition to their use among males on religious grounds (Obionu, 1996). In contrast, a survey done in Khartoum Sudan showed a strong positive attitude towards FP services by men, with few actually using a method. Similarly, a study in Danfa in Ghana came out that more than two thirds of rural men approved and accessed FP services, and that men knew at least one modern method and they also prefer visiting mobile clinics for obtaining condoms rather than buying them in a chemical shop (IPPF, 1984). This situation was common in most of the health centers due to the un-conducive environment and the fact that the health facilities are not male user-friendly.

A survey conducted on men's approval and accessing FP, (Adwoba 2008) established that some factors have significant effect on access and utilization. Another study carried out in Kenya further supports the observation that men's knowledge about FP correlate with its use. However, despite the fact that men's knowledge of contraceptives was quite high, contraceptive use by men remains uncommon. Men who

did not want to use FP, perceived it to be bad for health, and that it was against their religion. Again due to rumors and misconception about FP, many men expressed fear about the safety and performance of modern methods. In addition men perceived that contraceptive used by women could threaten their fidelity in marriage. (McGinn 2009). According to a research done on men's knowledge, attitude and practice of FP in Enugu south-eastern Nigeria, the result showed that a high proportion of men had knowledge of and possessed positive attitude to FP even though, a lesser proportion actually used the methods.

The poor utilization pattern was due to many reasons, which includes consequences of such moves as being against God's wish, it also exposes both men and women to sexual promiscuity, as well as exposing people to 'evils' of modernization which brought no respect to sexual and traditional values (Obionu et al., 2006). Another survey explored the knowledge, attitudes and practice of FP among men in Ngara district, Tanzania. It was cross sectional, using structured questionnaire and focus group discussion. During the study it was revealed that the male contraceptive prevalence was low and knowledge of male method was also limited. This view was different from what was known about men's knowledge on FP. Various studies have shown that there was no direct relation between knowledge and utilization of FP service by men. Besides, men perceived that male methods such as vasectomy are associated with castration while condoms reduce sexual sensation on the part of men. (Ndenzako, 2008) this can easily result in the spread of sexually transmitted infection including AIDS.

According to a study done in Bangladesh, a focus group discussion was employed to assess male knowledge and attitude towards FP, the way they use what they know, and others. It was noted that men have knowledge and positive attitude about FP methods but are reluctant to use it. The reason for which could be attributed to various factors (Dhaka, 2006). A study done in Ouagadougou revealed that sizable number of men knew at least one modern contraceptive method, if they are prompted with a brief description of the method but surprisingly, due to some kind of perception they have about FP, they failed to utilize it.

Many other studies have showed that females are more knowledgeable than men about FP issues. This information gap however, still poses relatively, low participation of men in FP this indicate that only small proportion of men share fertility regulation responsibilities and prevention of sexually transmitted infections including AIDS. This was because of the fact that, men have a very limited choice of contraceptive methods (Population Council Dhaka, 1998).

According to a study conducted in Pakistan on men involvement and use of FP methods. The objective of the study was to examine the changes in knowledge and attitude of men about FP and estimate the extent to which it affects their contraceptive behavior. The study revealed that men's knowledge and contraceptive use has increased within a certain period. Although men's knowledge about FP has increased, utilization of the service was not encouraging. (Kiani 2003). Study on existing knowledge of male participation in reproductive health including FP was done; the purpose of the study was to overcome specific obstacles, such as men's disapproval of contraceptive use by their partners and themselves, resulting in low utilization. Also pre-conceptions on the part of the service providers, that men are disinterested in taking responsibility for FP, and inadequate information on male contraceptives and male attitude was also considerable (Greene et. al 1996) A study on men's perception done in Mwanza, Tanzania indicated that males are not using the FP service themselves because they believe it was bad for health, and condom was also perceived negatively for multiple reasons for instance, the method was associated with getting infected, becoming promiscuous and could reduce male sensation and sexual pleasure (Bongaarts,2006). Similarly, a study has shown that a male method such as vasectomy was considered a form of castration. This was preventing men from using it, but for men to use a particular method there should be intensification on effective information education and communication for men (Nzioka, 2001).

Studies carried out in the sub-Saharan regions has shown that men hold certain traditional beliefs and misconceptions regarding modern contraception which act as barriers to them using these methods or even approving use by their sexual partners. For instance men have been found to think that FP was woman's issue and also they associate female contraception with increased promiscuity and again think that other methods make women unresponsive during intercourse. This suggests that men who subscribe to these notions may not approve of their partners use of the service (Fapohunda and Rutenberg, 2000) and even fail to use it themselves. According to a study conducted on knowledge of and attitudes about FP and its use by a convenience sample of men in Ghana. It indicated that increase in knowledge has significant effect on the respondents. The study again identified socio-cultural misconceptions resulting from lack of knowledge and education as the.

2.6. Traditional Beliefs and male participation

The principle of informed choice focuses on the individual. Yet most people's FP decisions also reflect a range of outside influences. Social and cultural norms, gender roles, social networks, religion, and local beliefs influence peoples' choices (Bosveld, 1998). To a

large extent, these community norms determine individual childbearing preferences and sexual and reproductive behavior. Community and culture affect a person's attitude towards FP, desired sex of children, preferences about family size, family pressures to have children and whether FP accords with customs and religious beliefs, (Dixon-Meuller, 2000). Community norms also prescribe how much autonomy individuals have in making FP decisions. The larger the differences in reproductive intentions within a community, the more likely that community norms support individual choices (Bosveld, 1998).

Household and community influences can be so powerful that they can obscure the line between individual desires and community norms. For instance, in some culture, many women reject contraception because bearing and raising children was the path to respect and dignity in the society (IPPF,1996) In either country most women use contraception because having small families was the norm(Mkangi, 2001)). People are often unaware that such norms influence their choices. In other cases they are particularly aware. For example, young people often decide not to seek FP because they do not want their parents or other adults to know that they are sexually active. Many fear ridicule, disapproval and hostile attitude from service providers and others (Jejebhoy, 2004).

A person's social environment usually has more influence on FP decisions than do the attributes of specific contraceptives. In Kenya, for example, when new clients were asked to give a single reason for their choice of a specific FP method, most cited the attitudes of their spouse or their peers, or their religion or value (Mucheka, 1998). In many countries FP programs are part of national economic and social development efforts. Efforts to foster equity in decision-making and raise awareness about reproductive right of the family, community, and society also promote informed choice of FP (Jacobnson, 2000). As women gain more autonomy, they are better able to claim their rights as individuals, including the right to act to protect their own reproductive health (Barnett 2001).

Everybody belongs to informal social networks that influence their behavior to some degree (Montgomery, 2000). Social networks include the extended family, friends, neighbors, political groups, church group, youth groups, and other formal and informal associations. During the course of the day, women often speak to other women about FP and experience with contraceptive use. For many women, informal communication was a primary source of FP information Rutenberg and Watkins, (2002).

The influence of social networks was crucial to informed choice. Most people seek the approval of others and modify their own behavior to please others or to meet others' expectations (Stash, 2000). Individual health behavior was influenced by how a person thinks

that others view their behavior. In Nigeria and other West African Countries for example, some women said that, it was difficult for them to use FP because their relatives or friends were not using it. These women were reluctant to be the first in their social group to use FP, Stash (2000).

People choose contraceptive methods that are commonly used in their community because they know that it was socially acceptable to do so, and they tend to know more about these methods (Rogers and Kincaid, 2004). Many women use the same FP method that others in their social networks use Godley, (2001). A 1998 study in urban Nigeria found that the more widely used a method was, the more attractive it became to others in the cities and villages Entwistle (1999). Entire communities may encourage one type of contraceptive based on the choices of early contraceptive users, rather than individual needs. Even when people are aware of the side effects or failures experienced by other users of a method, sometimes they still prefer it because it was familiar Lutz, (2003).

While social networks exerts a strong influence on more people's reproductive attitudes and behavior, FP programs themselves influence social norms through the diffusion of new ideas about contraceptive use Cleland, and Mauldin,(2001). Based on a review of studies over the previous two decades, research in 1996 found that programs have helped convert people's interest in having fewer children into a definite demand for contraception. They have done so largely by making contraceptive use more accessible, common and acceptable in many communities Freedman (1997). FP programs are often the deciding factor for people who want to avoid pregnancy but who feel uncertain about using FP Jainnet. (1999).

2.7. Theoretical Framework

The theory of Thomas Malthus was founded on the assumption that food and passion for both sexes are the two most essential elements for human existence. He observed that while the population growth takes a geometrical pattern, the food production increased in arithmetical rate. If this population was left unchecked, there would be a great competition for the scarce resources by the increasing individuals. He however observed two kinds of checks that would create a balance between food production and the population. These were preventive and positive checks. The preventive checks consist of voluntary and conscious measures by individuals to control their fertility based on their income and the quality of life they anticipate. Positive checks are a direct consequence of lack of the preventive checks. When a society does not limit its population voluntarily, diseases, wars, famines reduced the population to strike a balance with resources.

The Health Belief Model (HBM) further explains the variability for taking a health related action. It comprises of three concepts; individual perception, modifying factors and likelihood of taking an action and four health beliefs (related factors) which influence health behavior namely: perceived susceptibility; perceived risk; perceived benefits and perceived barriers. The HBM assumes that a person takes a health-related action if that person perceives that was susceptible to a serious or severe health consequence (individual factor) and feels that a negative health condition can be avoided. Demographics like prior experience with a serious condition, knowledge of a condition, peer or social pressure would help the person perceive that she/he might be susceptible to a health condition. This also helps to perceive the threat of not taking the required action and see benefits of taking a recommended health action to avoid a negative health condition. This activates the readiness and stimulates overt behavior to overcome barriers to taking a health related action. Cues to action (like education, information and having symptoms of a condition) acts as reminders, also promotes perceived risk then this leads to likelihood of taking a recommended health action Glanz K, Rimer BK, Lewwas FM, (2009).

In this study, it was suggested that prime motivation for pregnant women to initiate ANC in time would be if they perceive that they are susceptible to bad pregnancy outcomes / serious pregnancy conditions. Similarly, the perceived threat of adverse maternal or neonatal outcome could motivate pregnant women to initiate ANC in time. Prior experiences could affect how women perceive their susceptibility, severity, benefits and barriers. For example, pregnant women who believe that starting ANC in time was beneficial to prevent adverse pregnancy and neonatal outcomes identify their barriers to initiating ANC in time (like beliefs, attitudes, religion, gender inequalities, long distance and waiting hours) and explore ways to eliminate or reduce these barriers.

ANC education, information, mass media communication on ANC services or having symptoms of pregnancy condition acts as a reminder and facilitate the likelihood of initiating ANC in time, increase perceptions of being at risk of maternal and neonatal death and in turn trigger the decision making process whereby perceived barriers and benefits are weighed against each other to start ANC in time.

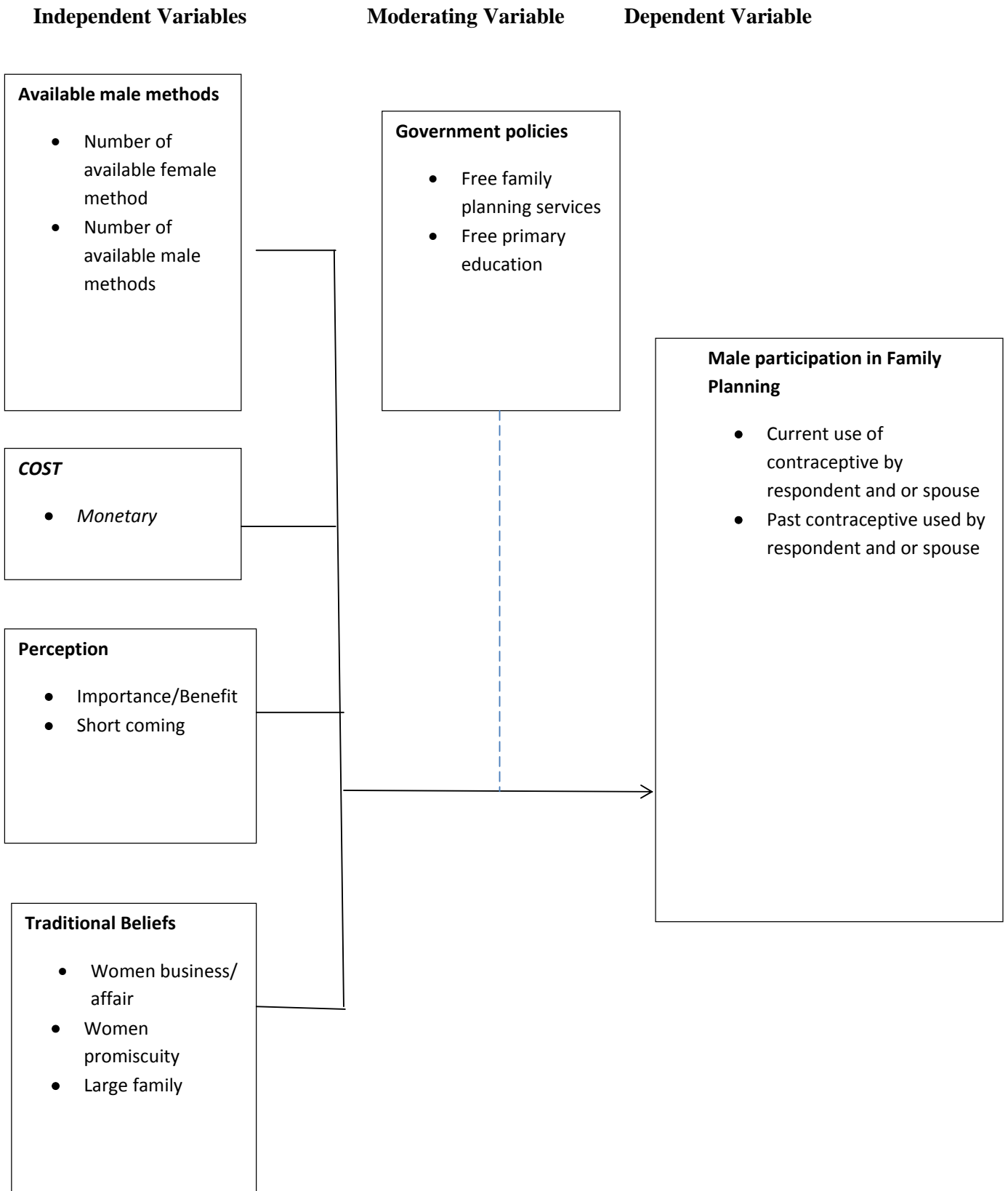
2.8. Conceptual Framework

The review literature has shown that FP programs have not achieved its goal hence population growth rate increases with decreased /scarce resources. It has also been revealed that the current male participation in FP was very low despite them being aware of the programs .This has translated to low married women uptake of FP and high drop rate for the few that had engaged.

As the situation continuous, the human population growth will be uncontrolled hence population explosion which will threaten Sustainability of human life.

It's worth noting that a lot has been done in Kenya and other Countries to make FP program a success through sensitization programs, establishment of department of reproductive, health and FP as the main pillar in women and children welfare. There was need for good was among all players in order to ensure that such efforts must yield good results. Apart from good will, there is also need to emulate success stories from other Countries that have practiced male participation by emphasising on couple counselling in prenatal, antenatal and postnatal Clinics.

CONCEPTUAL FRAMEWORK



In order to enhance male participation in FP in Kutus Township, it was conceptualize that factors such as available male FP methods, cost of FP, men perception and traditional beliefs need to be re-looked with the aim of striking a balance. The result of this synthesis was an increased awareness of the influence of these factors hence informs the planners on the mitigation measures.

Male involvement was important and was influenced by many factors among them being the lack diverse methods- this means that there are limited methods for men to choose from compared to women. These methods include male condoms and vasectomy.

Cost; is the expense that the men have to incur. Men perception- the perception towards FP and traditional belief, directly determine the participation. Also government policies influence the men participation. Some of such policies are, free FP, and free maternity services, free care for under-fives and free primary education. Participation of men was dependent on these factors among others.

2.3. Summary and Research gaps

The literature reviewed showed that FP has a lot of benefits to the community as a whole. It was also apparent from the literature that some factors can influence the possibility of a man involving himself in FP issues. It's also apparent that men have often been neglected in FP issues. Even though the literature shown that knowledge and awareness of FP was widespread among men, the rate of involvement in FP was still low among males as compared to females reddy (2003). Perhaps this might explain why maternal and child health indicators are still worrying in terms of mortality and morbidity in the country. There has been little effort to look at the factors influencing male participation in FP consequently, there was need to conduct a study on factors influencing male involvement in FP. And although some factors have been associated with male involvement in FP, their association was not well known due to unavailability of data.

CHAPTER THREE:

RESEARCH METHODOLOGY

3.1. Introduction

This section covers the procedure used in conducting the study. Pertinent issues discussed in this chapter included the target population, sample and sampling techniques to be used in the research design, a description of tools used in collecting the data, the measurement of variables and the techniques used in analysing the collected data.

3.2: Research Design

The study used descriptive survey design to yield quantitative and qualitative data on factors influencing male participation in family planning a case of Kutus Township in Kenya. Descriptive survey design involves collection of data from a sample of a population in order to determine the current status of that population with respect to one or more variables (Mugenda and Mugenda 2003). Bryman (2007) suggests that bringing quantitative and qualitative findings together have the potential to offer insights that could not otherwise be gleaned.

3.3. Target Population

Population has been defined as a group of individuals having one or more characteristics in common that are of interest of the researcher (Amin,2004) Mugenda (1999) also defines population as the entire group of individuals events, objects, having common observable characteristic.

This study targeted the population of all men and women and health workers in Kutus Township of 20 years and above. This age group was targeted because is the age where according to WHO people are defined as adult hence has the right to engage in sexual activity and are also in the child bearing age. Age was important component in this study since they can give coherent responses and true experiences comfortably. The health workers are crucial in this study since they are main shapers of community perception, attitude and believes on health matters and they are respected in the society. Despite that, they offer these services to the community thus having added advantage over the others to interact with all types of people. Men's participation was the main focus of the study and this necessitates the involvement of women for triangulation purpose since men may not be willing to completely disclose their reasons. By including women sensitive information was be gathered. According to KNBS 2009 there were 528,000 people living in Kirinyaga County. Those 20 years and

above: total 266,090: Males 145,707 Female, 120, 383.in Kutus township there were 2443 people. Those above 20years were 2076(1051 males, 1025 female) there is one health centre with 10 health workers.

3.4. Sample size and Sampling Procedure.

Best and Khan (1999), define the target population as a small portion of the population Sampled for Observation and analysis. It was also Considered as the population to which the researcher used Stratified Sampling which Increases precision (Kiplagat 1999) to obtain the sampling frame composed of three categories. The first category was composed of health workers and second category was male and Third females in the area .According to Mugenda and Mugenda (1999), for descriptive studies, 10% of the accessible population is adequate for a sample.

The target was adult 20years and above. The population was 2076 and 10 health workers.

The entire health workers were interviewed and 10% of the accessible population.

$$2076 \times 10/100 = 208 \text{ subjects.}$$

$$208 - 10 \text{ health workers} = 198$$

The researcher increased by 2

Total sampled 210.

Table 3.1 Sample procedure Matrix

S/N	CATEGORY	TOTAL
1.	Health workers	10
2.	Men	100
3.	women	100
	TOTAL	210

Both probability and non-probability sampling technique was used to ensure good representation in all categories .The researchers used convenient sampling technique the male and female. However for the health workers the purposive sampling technique which is a non-probability sampling technique was used where the health facilities in charge were interviewed.

3.5: Data Collection Methods and Procedures

This section explains how data was collected, processed analysed and reported. Questionnaire and interviews guide were the main instruments of data collection. The questionnaire contained both closed and open ended questions. The questionnaire was interviewer administered. This was whereby a trained interviewer was conducting a one on one interview with the respondents and fill in their responses in the questionnaire. The questionnaires had predetermined questions grouped together to address particular objective of the study. Majority of the questions were structured, while the remaining were unstructured this was because the researcher wanted to gather as much information as possible about perception on FP. Questions on personal information such as gender, age and education were also asked. The main reason for using interviewer administration methods of collecting data were to ensure that the questions were not misunderstood to assist illiterate respondents and to minimize the risk of collecting incomplete and wrong information as it was with questionnaires particularly especially when people were unable to understand the questions considered by the researcher as the most appropriate in providing a safe basis for generalization and high accuracy.

Both structured and semi-structured interviews procedures were used .Once the schedule was ready the researcher pre-tested it to ascertain that the questions are properly worded and easy to comprehend. The researcher selected ten personnel from the three categories of the sample population, the male, female and health workers. The subjects involved in the pre-test were encouraging to make comments and suggestions concerning instructions, clarity and reference of the questions. This enabled researcher to test for the reliability and validity of the data collection instruments.

Qualitative data was collected through in-depth interviews with target respondents. There were a total of five in-depth interviews, three with male respondents and two with women respondents

3.6. Research Instruments

The researcher used questionnaires and interview guide to collect data from the target respondents. Questionnaires are pre- formulated written set of questions to which respondents record their answers, usually within rather closely defined alternatives (Sekaran Uma, 2003). The questionnaire was semi structured in nature in that it contained both open ended and closed type of questions. The questionnaire was pretested with a few respondents before embarking on the actual data collection. The pretesting was aimed at determining whether

there was flow in the arrangement of the questionnaire and identifying any inconsistencies. The researcher used the feedback from the pretesting to improve the questionnaire. The questionnaires were interviewer-administered. The main advantage of this was that the researcher collected all the completed responses within a short period of time.

3.7 Validity of research instruments

An instrument is said to be valid when it measures what it claims to measure or the extent to which it predict accurately. It is actually the degree to which an instrument actually measures the variable it claims to measure. To ensure validity, pre-test study was done to ten randomly selected respondent's .Research experts including the supervisor were consulted to ensure that the instrument measures what it was intended to measure and a peer review was done.

3.8 Reliability of research instruments

Reliability is the ability of the instrument to consistently yield the same results when repeated measurements are taken of similar individuals under the same conditions. Reliability was ensured using triangulation by featuring similar questions in the questioner using different language.

3.9 Data analysis techniques

Completed questionnaires were edited for completeness and consistency. The data was then be coded and checked for any errors and omissions. Data was analysed using descriptive statistics such as percentages and arithmetic mean scores. Frequency tables were drawn using Statistical Package for Social Sciences (SPSS) software. The data from the interview was analysed in themes.

3.10 Ethical considerations

The researcher maintained research ethics by following the procedure outlined, by seeking permission from the relevant authorities before carrying out the study. Honesty and integrity was highly maintained throughout the study

TABLE 3.2 OPERATION OF THE VARIABLES

OBJECTIVE	TYPE OF VARIABLES	INDICATE OR	MEASURE	MEASURE MENT SCALE	TYPE OF ANALYSIS	TOOLS OF ANALYSIS
To determine the extent to which available male FP methods influence men's participation in FP.	Independent variable: diversity of methods	Male methods	Number available methods	Nominal	Descriptive	Percentage
		Female methods	Number of available methods	Nominal	Descriptive	Percentage
To determine the extent to which cost influence men's participation in FP	Independent variable: expenditure	Service charge	Perceived cost	Ordinal	Descriptive	Mean
To determine the extent to which perception influence men's participation in FP	Independent variable: men perception	attitude	Men attendance/ Uptake	Ratio	Descriptive	Mean
		Benefit	Consistency/Retention rate	Rate	Descriptive	Mean
		Short comings	Discontinuation Dropout rate/	Ratio	Descriptive	Mean
To investigate whether traditional beliefs influences male participation in FP	Independent variable: traditional beliefs	Prestige in big families	Number of desired children	Nominal	Descriptive	Mean
		Men respect in the society	Levels of agreement	ordinal	descriptive	Mean
Male participation in Family Planning	Dependent variable: men participation	Current use of Contraceptive by respondent and or spouse	Number on FP currently	Ratio	Descriptive	Mean
		Past contraceptive by respondent and or	Awareness	Nominal	Descriptive	Percentage
		Discussion with the partner about method choice	Awareness of spouse method	Nominal	Descriptive	Percentage

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1. Introduction

This chapter provides the findings obtained from the survey. This includes both the quantitative data and qualitative data. The quantitative data has been presented using frequencies, percentages and mean scores. Interpretative analysis has been used to attach meaning to each of the scores obtained quantitatively.

The qualitative data has been summarized and presented using interpretative analysis and qualitative matrices.

4.2 Return rate.

The researcher Distributed 200 questionnaire which were filled and picked at the sometime. 200 questioner were returned making the return rate 100% this was made possible by the mode of distribution and collection. Therefore the data collected was very reliable and acceptable as Mugenda & Mugenda(2003) a response rate of 60% is good and a response rate of 70% or more is even better for Social research. All the health workers were interviewed giving 100% response rate.200 and 10 were the base totals for the clients and health workers respectively.

4.3. General characteristics of respondents

The study assessed the demographic data of the respondents which included their gender and the results are presented in Table 4.1.

4.3.1 Gender of the respondents

Both men and women were targeted in the survey since the aim of the survey was to establish the factors that influence men's participation in FP services in general and the data presented in table 4.1

Table 4.1: Gender of respondents

Gender	Frequency	Percentage
Male	120	60
Female	80	40
Total	200	100

Table 4.1 shows that 60% of the respondents were male whereas 40% were females. This indicates that the study result is more indicative of FP use by men more than women.

4.3.2 Age of the respondents

The respondents were asked to indicate the age brackets they were in.

Table 4.2: Age of respondents

	Frequency	Percent
18-24	27	13
25-34	100	50
35-44	35	17
45- 50	19	10
Above 50	19	10
Total	200	100

Table 4.2 illustrates that most of the respondents (50%) were aged between 25- 34 years and the least were ages 45 and above at 10%.this indicate that the study result is more indicative of FP use among the youth rather that the elderly.

4.3.3 Marital status of the respondents

The respondents were asked to tell of their marital status and the result.

Table 4.3: Marital status of respondents

Marital status	Frequency	Percent
Married	158	79
Single	35	17
Divorced	4	2
Widower	4	2
Total	200	100

Table 4.3 shows that 79% of the respondents were married while 17% were single and 2% were either divorced or widowed. This indicates that the study result is more indicative of contraceptive use in a marriage set up rather than out of marriage.

4.3.5. Employment status of the respondents

The cost of living is gradually going up and most Kenyans earn below a dollar a day. The study sought to know the employment status of the respondents.

Table 4.5: Employment status of respondents

Employment status	Frequency	Percent
Student	4	2
Formal employment	62	31
Informal employment	19	10
Unemployed	15	8
Self-employment	88	44
Retired	12	6
Total	200	100

Table 4.5 shows the employment status of the respondents who participated in this survey. It was evident that 44% of the respondents were self-employed while 31% were in formal employment. 6% of the respondents were retired. This indicates that the study result is more indicative of economically empowered people rather than the poor.

4.4 Influence of availability of male FP methods and men's participation in FP

Although the objectives of this survey were very specific given that the main objectives were to establish factors influencing male participation in FP, the researcher believed it was important to start by understanding the respondent's awareness of FP in general. Respondents were asked to rate their level of knowledge about FP.

that majority of the married respondents had fair information on the FP at 66% and 24% of the female had a lot of information.

4.4.1 Respondents' understanding of FP

Respondents understood FP in various ways and Table 4.9 presents the result.

Table 4.6: Respondents Understanding of FP

Understanding of FP	Frequency	Percent
Child Spacing	108	54
		23
Few children	46	15
Prevention of pregnancy	31	8
No idea	15	
Total	200	100

The Table 4.6 indicates that most (54%) respondents understanding was child spacing while others understood FP as getting few children and 8% had no idea about FP.

4.4.2 Awareness of available FP methods

Having established that most respondents have some knowledge of FP, the researcher sought to determine whether respondents are aware of the various available FP methods. Respondents were therefore asked to state the common methods available for FP and Table 4.10 present the result.

Table 4.7: Awareness of FP methods

	Total		Male		Female	
	Frequency	%	Frequency	%	Frequency	%
Condoms- male	51	98	31	100	21	100
Oral pills	42	81	31	100	20	95
Injectable	40	77	22	71	20	95
Condoms- female	34	65	22	71	18	86
Implants	26	50	16	52	18	86
Natural methods	25	48	10	32	16	76
IUCD	20	38	15	48	10	48
Vasectomy	14	27	10	32	10	48
Diaphragm	9	17	6	19	8	38
Tubal ligation (BTL)	9	17	4	13	5	24
Spermicides	1	2	2	6	7	33

Table 4.7 indicates that, male condoms have the highest awareness levels of 98% followed by oral pills, injectable and female condoms at 81%, 77% and 65% respectively. However majority of the respondents were not aware of the spermicidal only 2% were aware. Female respondents were more aware on fairly all the methods compared to their male counterpart.

4.4.3 The sources of FP methods information

The researcher questioned the source of FP information to the respondent. The respondents were asked to indicate their source of information about the FP and Table 4.8 presents the result.

Table 4.8: The sources of FP methods information

	Total		Male		Female	
BASE	52	100	31	100	21	100
From adverts in the media	39	75	21	68	18	86
From posters in the health center	23	44	11	35	12	57
From my friends/ relatives	15	29	6	19	9	43
Learning from school	2	4	1	3	1	5
Education from hospitals	1	2	0	0	1	5
Reading from magazines	1	2	1	3	0	0

Table 4.8 shows that the main source of awareness for the various FP methods was the media adverts at 75% and posters from the health centers 44%. It was noted that posters from the health centers have played a greater role in creating awareness among women 57% compared to men at 35%. 29% of the respondent learnt from friends and relatives. More women learnt from this source more than the men counterparts (43%, 19%) respectively. Learning from school was least rated among the sources at 4%.

4.4.4 Main FP methods used by the respondents

The respondent were asked to indicate the methods used for their FP and Table 4.9 shows the result

Table 4.9: Type of FP used by respondent

What type of FP method are you using currently						
	Total		Male		Female	
	Count	%	Count	%	Count	%
BASE	100	100%	58	100	42	100
Condoms- male	62	62	58	100	4	9
Implants	27	27	0	0	27	64
Natural methods	8	8	0	0	8	18
Oral pills	4	4	0	0	4	9

Table 4.9 shows that 62% of the respondent used male condoms with 100% of the men using the same. However 64% of women used implants and 8% of the respondent using natural methods.

Male family planning lack diversity, This was evident from the study findings where 70% of the respondent agreed that the available male method lacked diversity, this concur with Greene (2005) who indicated that the range of family planning methods available for men was limited, and this as a result inhibits men's capacity to participate in fertility regulation. In Kenya where the study was done there are only three methods available for men: Male condoms, Vasectomy and natural methods. The study revealed that 100% of the men who reported using Family planning method used male condoms, and 0% used natural methods like withdrawal and abstinence. The modern Family planning methods available are mostly for women and this was evident in the study where 64% of female respondent used implants, 18% natural methods and 9% used oral pills and condoms despite the use of this methods respondent demonstrated high level of awareness of eleven methods of Family planning but on average women were more aware of all the method compared their counterpart males. The respondent indicated that if male methods were many then men would participate more.

4.5 Influence of cost on male FP methods and men participation in FP

The researcher inquired whether the cost of male FP methods influences participation. Respondents were asked to indicate the extent to which they agree or disagree with various attributes on Cost of FP A 5 likert scale was used to measure the level of agree meant and disagreement. A rating of 5 indicated that a respondent agreed strongly with that particular statement while a rating of 1 indicated that a respondent disagreed strongly with a particular statement. The result were then converted into percentages and are presented in the Table 4.10

Table 4.10 Cost of male FP

	%		
	Total	Male	Female
FP methods available for men are expensive	77	72	83
Male FP methods are too expensive/ unaffordable	74	74	75
If this methods are free many men can participate	70	67	74

Table 4.10 shows that 77% of the respondent indicated that the methods are expensive and unaffordable and 70% indicated that if all the methods are offered for free then more men would participate.

Influence of cost of Family planning on male participation was another objective of the study; Kenya is a developing country where majority of its citizen live below a dollar a day. This means that poverty level is high and according to Maslow's hierarchy of needs he states that an Individual will Struggle to satisfy the basic needs first before moving up the hierarchy. The study demonstrated cost as a barrier to the uptake of Family planning among men with 77% of the respondent holding the opinion that the available male Family planning methods are too expensive and affordable and 74% were of the opinion that if Family planning was made free then more males would participate according to the 2003 KDHS, 53% of Family planning users obtained contraceptive through public facilities while only 5% obtained contraceptives through private medical. Majority of the male client had to travel for the services at less cost (En, som—ach & Kanitha, 2004)

4.6 Influence of male perception towards FP and men participation in FP

Perception is a belief or mindset held by someone about a person or something. The respondents were asked to state in their opinion on who should ensure FP methods are used in families. This was to assess the perceived roles of family members and the community at large. Table 4.11 presents the result.

Table 4.11: Role of various stakeholders in promoting use of FP methods

In your opinion, who should ensure that FP methods are used in families?

	Total		Male		Female	
	Count	%	Count	%	Count	%
BASE	200	100	31	100	21	100
Both the woman and her spouse	165	83	24	77	19	90
The woman	27	13	5	16	2	10
The government	8	4	2	6	0	0

Table 4.11 shows that majority of the respondent were of the opinion that both men and women should ensure use of FP methods and 16% of men having an opinion that women should ensure however the role of government was rated at 8%. Both men and women feel that promoting use of FP methods was the role of both genders.

The study assessed how various perceptions would be rated by the Respondents most male respondents agree with the following statements: FP was women business/role (78%), Men who use FP are disrespected in the society (79%), FP was a woman's affair (75%) and I fear my spouse may become promiscuous if they use FP (81%). 75% indicated perception that it is prestigious to have a big family, 59% perceived that the FP services targets women only.

Male perception on Family planning influence their participation and this was evident from both the literature and the study findings. A survey conducted in Dan forth (1999) indicated that overwhelming reliance on female methods of contraceptives had led to the assumption on the part of many men that contraceptive was only for women. From the study 61% of the male respondent held the perception that Family planning services target women and 19% thought that Family planning is Wife's affair. The main perception that prevent men from participation in Family planning that men perceive available method as ineffective (31%) This concur with McGinn, et.al 2009) who said that due to rumours and misconception about Family planning , many men expressed fear about the safety and performance of modern methods and men perceived that contraceptive used by women would threaten their fidelity in marriage.

4.7 Influence of traditional beliefs towards FP and men participation

The principle of informed choice focuses on the individual. Yet most people's family planning decisions also reflect a range of outside influences. Social and cultural norms, gender roles, social networks, religion, and local beliefs influence peoples' choices Bosveld, (1998).the study sought to examine if there were traditional beliefs in the community of the study.83% of the respondents believed that there were traditions beliefs in the community that influence the participation of men in FP. This was an opinion that was held by both men and women but 17% held a different opinion on the same. The main traditional belief that hindered men from use of FP methods are the beliefs that men should have many children so as to be real men (masculinity) in the community at 78% More men (80%,) than women held this opinion (75%,) .6% Of the male respondent indicated that men are supposed to increase the population.

The study further evaluated how various attributes of traditional beliefs on FP were agreeable to the respondents. Most respondents agree with the following statements: Men who use FP are disrespected in the society (82%), My religion doesn't accept FP (77%), It is prestigious to have a big family (77%) and Traditionally FP is not acceptable (55%) .

From the study 82% of the respondent had the opinion that the men who use FP are disrespected in the society. 54% of the male respondents indicated that traditionally FP is not acceptable. To a large extent, these community norms determine individual childbearing preferences and sexual and reproductive behavior. Community and culture affect a person's attitude towards family planning, desired sex of children, preferences about family size, family pressures to have children and whether family planning accords with customs and religious beliefs, (Dixon-Meuller, 2000). This was well demonstrated in study findings were 75% of the male respondents find prestige in big families. Community norms also prescribe how much autonomy individuals have in making family planning decisions. The larger the differences in reproductive intentions within a community, the more likely that community norms support individual choices (Bosveld, 1998).

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the findings and draws comparisons with the findings of similar studies that have been undertaken by other researchers. The independent and dependent variables have also been scrutinized based on the findings from the survey and conclusions made as to role of each variable on the male usage of Family methods or the lack.

5.2. Summary of Main Findings

The purpose of this study was to determine the factors influencing male participation in family planning in Kutus Township in Kenya. The researcher sampled 210 adult aged 20 years and above from the study area, where a total of 100 men, 100 women and 10 health workers were involved in the study. The section is organized according to the objective of the study.

The available FP methods do influence in male involvement in FP to some extent. 70% of the respondent agreed that available male method lacked diversity and 57% of women were of the opinion that the methods were inadequate. 31% of respondent were of the opinion that men fail to participate in FP because they lack effective methods. 64% of the respondent held the opinion that if male methods were many then more males would participate.

The research findings did demonstrate the element of cost as a barrier to the uptake of FP among men. 77% of the respondent were of the opinion that the available family planning methods for men are too expensive and unaffordable, 74% were of the opinion that if FP was made free then many men would participate. This opinion was held among the economically empowered with 44% self-employed and 31% formally employed.

The main perceptions that prevent men from participating in FP are the perception that men do not have effective methods of FP at 31% and that FP was a wife's affair (19%). 82% of the respondent held the opinion that men who use family planning are disrespected in the society and 79% of male respondent shared the opinion. 81% of the male respondent feared that their spouse would become promiscuous if they used FP. 61% of the male respondent held the perception that FP services target women.

Traditional beliefs play a major role in influencing male participation in FP. 75% of the male respondent find prestige in big families. 54% of the male respondent agreed that traditionally FP is not acceptable. 82% of the respondent held the opinion that men who use family planning are disrespected in the society and 79% of male respondent shared the opinion. Bosveld, (1998).

5.3 Conclusions of the study

There was adequate awareness of FP and its importance both among men and women. Range of family planning methods available to men is limited, and this as a result inhibits men's capacity to participate in fertility regulation. Greene (2005). There however seem to be higher awareness of female FP methods compared to the male FP methods. This raises the issue of diversity for FP methods for men in influencing uptake of the same. All of the men who stated that they use FP methods were using the male condom as opposed to women who were using varied methods such as the pill, injectable and implants.

It can be concluded that the key barrier to uptake of FP by men was mere attitude or negative perceptions towards FP by men and the belief that FP as a woman's affair because they are the ones who get pregnant. To this effect, it was noted that most male respondents said their spouses are on FP while most women respondents stated that their spouses were not using any FP methods. Both men and women respondents also agreed that women participate more in FP than men. Some of the perceptions that lead to low uptake of FP among men are the perception that male FP methods are rare and not convenient/effective.

5.4 Recommendations of the study

Male involvement in FP has a positive impact in the general wellbeing of the family and hence the following measures should be taken in order to increase participation:

1. Kenyan government and the WHO should strive to introduce new male FP methods in order to increase diversity and this will come a long way in improving current male participation and create awareness on the need for male participation in the same and the benefits that can be achieved through more male participation. There was also lack of awareness on the effectiveness of the available male FP methods
2. The government to ensure that the FP supplies especially the male condoms is consistent and sustainable since men prefer condoms to other male FP methods.
3. The formal education curriculum should include FP lessons in order to shape the mind of the people towards the right perception.

4. The stakeholders in MOH should organize co-ordinate and conduct workshops on change of negative traditional beliefs.

5.5 Suggestions for Further Research.

The study was about factors influencing male participation in FP in Kenya and focused in Kutus Township. The scope of the study was limited to investigating issues such as, available male FP methods, cost, and perception and traditional believes. In light of the finding, the study recommends the following areas for further study.

1. Factors influencing male participation in FP in Kenya. Since the study was conducted in Kirinyaga county which is rated to be the second richest county in Kenya ,the researcher would like the study to be rolled out to all parts of the country and the result compared since some of the factors may differ in different parts of the country.
2. Role of the Health workers in influencing male participation in F.

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APPENDICES

Appendix 1: Letter of Transmittal

Molly W. Muiga
University of Nairobi
Department of Extramural Studies

March, 2014

Dear respondent,

LETTER OF TRANSMITTAL

The researcher is a student of University of Nairobi pursuing a Master of Arts Degree in Project Planning and Management as a partial fulfilment of the conditions required for the award of the degree. The research study is meant to determine the Factors' influencing male participation in FP in Kutus Township in Kirinyaga County, with the intention of generalizing the findings in the whole of Kenya.

The questionnaire attached is to facilitate your participation in the study. Kindly respond truthfully and honestly to the questions. All responses will be handled with absolute confidentiality and will be used solely for the purpose of this study.

Thank you for your cooperation.

Molly W Muiga
Reg. No. L50/65540/2013
University of Nairobi

APPENDIX 2:

QUESTIONNAIRE FOR THE MEN AND WOMEN

INTRODUCTION

I am a student in university of Nairobi undertaking a master's degree. The study is on factors influencing men participation. The information given will be treated with confidentiality and will only be used for the purpose of this study. Sincerity in answering this question will be of value. Thank you

SECTION 1: DEMOGRAPHIC CHARACTERISTICS

1. Gender of the respondents: (Circle as appropriate)

Male.....1

Female..... 2

2. Age of respondent:

18-24	1
25-34	2
35-44	3
45- 50	4
Above 50	5

3. A) Marital status?

Married	1
Single	2
Divorced	3
Widower	4
Separated	5

3 B) If Married, Please Indicate Type of Marriage

Married monogamous	1
Married polygamous	2
Others (specify)	

4. Highest level of education attained

None	1	College diploma	5
Primary education	2	University (Bachelor's degree)	6
Secondary school	3	University (Master's degree)	7
College certificate	4	Other (Please specify)	

5. Employment status: (Circle as appropriate)

Student	1	Self-employment	5
Formal employment	2	Retired	6
Informal employment	3	Other specify.....	
Unemployed	4		

SECTION 2: MAIN INTERVIEW

6. A) How many children do you have?

1-3	1
4-6	2
7-10	3
Above 10	4

6 B) How many children would you like to have?

1-3	1
4-6	2
7-10	3
Above 10	4

7. How would you rate your level of knowledge about FP?

I have no knowledge about FP at all	1
i know very little about FP	2
i have a fair amount of information about FP	3
I have a lot of information about FP	4

8. What can you say FP is?

Child Spacing	1	Prevention of pregnancy	4
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11 B) If the response to question (11A) above was NO, give reason

Desire for more children	1	Not available	4
Wife opposition	2	Doesn't like	5
Religion	3	Others specify).....	6

11 C) If yes, which one (s) (tick appropriately in the table below)

	FP methods	Method(s) used by the respondent
(a)	Condoms- male	1
(b)	Condoms- female	2
(c)	Vasectomy	3
(d)	Natural methods	4
(e)	Injectable	5
(f)	Implants	6
(g)	Spermicides	7
(h)	IUCD	8
(i)	Diaphragm	9
(j)	Oral pills	10
(k)	Tubal ligation (BTL)	11
(l)	Don't know	12
(m)	Others (specify)	

12 A) Is your spouse currently on any FP method?

Yes.....1

No.....2

12 B) If yes, which one? (Tick appropriately on the table below)

	FP methods	Method(s) used by the respondents spouse
(a)	Condoms- male	1
(b)	Condoms- female	2
(c)	Vasectomy	3
(d)	Natural methods	4
(e)	Injectable	5

(f)	Implants	6
(g)	Spermicides	7
(h)	IUCD	8
(i)	Diaphragm	9
(j)	Oral pills	10
(k)	Tubal ligation (BTL)	11
(l)	Don't know	12
(m)	Others (specify)	

In your opinion, who should ensure that FP methods are used in families?

The woman	1
Both the woman and her spouse	2
The man	3
Health/ Medical personnel	4
The government	5
Other family members	6
Others (please specify)	

13 Do you think there are adequate/ enough methods of FP for men?

Yes.....1

No.....2

14 Who participates in **FP** in the community around? (**ONE ANSWER ONLY**)

Men participate more in FP than women	1
Women participate more in FP than men	2
Both men and women have equal participation in FP	3

15 A) In your opinion, are men supposed to use FP methods?

Yes.....1

No.....2

16 B) Why?

16 C) what are some of the things that prevent men from using FP methods?

16 How can the use of FP methods among men be increased?

17 A) Are there any cultural factors practiced in your community that influence the participation of men in FP?

Yes.....1

No.....2

18. B) Which are these factors?

19. Please tell me the extents to which you agree ion disagree with each of the following statements. Use a 5 point scale where 1 mean do not agree at all and 5 means agree strongly.

	Strongly disagree	Disagree	Neither agree	Agree	Strongly agree
Family planning was women business/role	1	2	3	4	5
FP methods available for men are expensive	1	2	3	4	5
If this methods are free many men can	1	2	3	4	5

participate					
Methods for men lack diversity	1	2	3	4	5
If men methods are many I think more men can use.	1	2	3	4	5
Traditionally FP was not acceptable.	1	2	3	4	5
My religion doesn't accept FP	1	2	3	4	5
Men who use FP are disrespected in the society	1	2	3	4	5
It was prestigious to have a big family	1	2	3	4	5
I fear my spouse may become promiscuous if they use FP.	1	2	3	4	5
FP services target women only	1	2	3	4	5
FP programs have done very little to involve men	1	2	3	4	5
Healthcare workers should invite men to FP clinics	1	2	3	4	5
FP was a woman's affair	1	2	3	4	5
Male FP methods are too expensive/unaffordable	1	2	3	4	5

20. Any other comment?

APPENDIX 3:

IN-DEPTH INTERVIEW DISCUSSION GUIDE FOR THE HEALTH WORKERS.

INTRODUCTION

I am a student in university of Nairobi undertaking a master's degree. The study is on factors influencing men participation. The information given will be treated with confidentiality and will only be used for the purpose of this study. Sincerity in answering this question will be of value. **Thank you**

- Do you offer FP services in your facility and which days of the week?
- What are the charges?
- How many staffs offer this service and what was their gender?
- On average how long does a client spend while seeking FP service?
- Why do you think most men do not participate in FP?
- What are the sources of FP in this community?
- Do you think men have a role to play in FP?
- In what ways can men get involved in FP?
- What do think can be done to make more men involved in FP