

**"FACTORS INFLUENCING MALE  
INVOLVEMENT AND  
PARTICIPATION  
IN FAMILY PLANNING IN KENYA"**



MGANGA, VERITY MGHOI

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

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**NOVEMBER, 2000**

## **DECLARATION**

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

Signed—  -  
Verity Mghoi Mganga (Mrs.)

This research project has been submitted for examination with our approval as the University Supervisors

Signed—   
**Dr. MURUNGARU KIMANI**

DATE- *jJILLI^OO*

Signed-   
**Dr. B.O.K'OYUGI**

DATE-

## **DEDICATION**

This project is dedicated to my parents who encouraged me to undertake the course. My brother Mwamburi and sister Chao who morally supported me during this time. To my sons Kala and Steve and my husband Mghanga, whose love support and encouragement saw me through.

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Thank you

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## **ORGANIZATION OF THE STUDY**

The project is represented in five chapters. Chapter 1 covers the general introduction, problem statement, objectives of the study, justification and the scope and limitations of the study.

Chapter 2 contains the literature review, the factors considered in the study (demographic, socio-economic and socio-cultural factors), the framework, variables and hypotheses used in the study.

Chapter 3 explains the source of the data used in the study, the quality of the data used and methods used to analyse the data.

Chapter 4 contains the representation of data analysis and result findings from the data used.

Chapter 5 finally includes the summary of findings, conclusions and recommendations from the study.



## **EXECUTIVE SUMMARY**

Men play a critical role in family planning as heads of households. African men are often key figures in domestic decision making, particularly about fertility behaviour and preferences and that authority is supported by tradition. The men are also the main link between the family and the prevailing culture and also the major players in bringing development to the home. Given the importance of family planning programmes in improving the health of women and children and in reducing population growth rates, men's support and involvement are essential for family planning to become widespread. Unfortunately, studies to investigate the fertility behaviour of African men for a better understanding of their reproductive intentions have been limited.

This study looks at the information about background characteristics of Kenyan men and how these promote or inhibit their knowledge and use of contraceptives. These factors have been used to explain why despite the high knowledge about contraceptives, use has remained very low. The paper gives recommendations or suggestions for action by policy makers, programmers and researchers for family planning programmes to succeed in Kenya.

The study has utilized secondary data from the Kenya Demographic and Health Survey (KDHS) 1998 which was conducted by the National Council for Population and Development (NCPD) in collaboration with the Central Bureau of Statistics (CBS). The Survey covered all areas of Kenya except the North Eastern Province and districts of Marsabit, Isiolo, Samburu and Turkana. The analysis in this paper is based on all 3407 men aged 15-54 years who responded to the survey.

## ACRONYMS

1. AIDS	Acquired Immune Deficiency Syndrome
2. CBS	Central Bureau of Statistics
3. FP	Family Planning
4. FPAK	Family Planning Association of Kenya
5. HIV	Human Immuno-deficiency Virus
6. ICPD	International Planned Parenthood Federation
7. IPPF	International Planned Parenthood Federation
8. IUD	Intra-Uterine Device
9. KDHS	Kenya Demographic and Health Survey
10. MCH	Maternal Child Health
11. NASSEP	National Sample Survey Evaluation Programme
12. NCPD	National Council for Population and Development
13. NFP	National Family Planning
14. STDs	Sexually Transmitted Diseases
15. TBAs	Traditional Birth Attendants
16. TFR	Total Fertility Rate
17. UNFPA	United Nations Fund Population Activities

# **CHAPTER ONE**

## **GENERAL INTRODUCTION**

### **1.1 INTRODUCTION**

Most African countries perceive rapid population growth as an obstacle to their social and economic growth and that this has continued to undermine their development efforts. Most of these countries, which view their countries' fertility levels as being too high, have adopted policies to lower their fertility. Family Planning programmes have been formulated and initiated in most of these countries aimed at curbing this rapid population increase. Explicit or implicit in these policies are interventions to improve access to and the quality of reproductive health care since the 1994 TCPD (International Conference for Population and Development).

Kenya has had an explicit population policy since 1967 when the national family planning programme was launched and integrated into the maternal and child health (MCH/FP) programme in the Ministry of Health. To supplement and compliment Government's effort in promoting family planning services in Kenya, are a host of international and national agencies such as the Family Planning Association of Kenya (FPAK), the Family Planning Private Sector (FPPS), International Planned Parenthood Federation (IPPF) and the National Council for Population and Development. The Government of Kenya established NCPD in 1982 to further improve the performance of the National Family Planning Programme.

Family planning programmes have long been recognized for their importance in improving the health of women and children in reducing population growth rates. These programmes have focussed primarily on women because of their (women) direct involvement in childbearing and the predominance of effective female methods. However, in sub-Saharan Africa and in some Muslim

cultures where men dominate reproductive decision-making, the exclusion of men from reproductive health, including family planning and sexual health activities may have contributed to low levels of utilization of such family planning services among women (Ezeh 1993).

Africa as a whole has lagged behind other world regions in the adoption and expansion of family planning. Since the introduction of the first family planning programmes in the 1950's, programmes have expanded throughout the continent but family planning information and services are still limited, particularly in sub-Saharan Africa. African men play a critical role in family decisions and therefore men's support and involvement are essential for family planning to become more widespread. But as indicated in earlier studies, men's involvement in family planning, either as users of male methods or supportive partners of users has largely been ignored by family planning programme planners and service providers. Most modern contraceptives developed over the past few decades have been for women with very limited choices for men.

According to Roudi (1996) the AIDS epidemic has been an important factor in bringing male involvement in family planning to the forefront of African policy agendas. The spread of Sexually Transmitted Diseases (STD's) including HIV/AIDS, has posed a challenge to African policy makers to develop strategies to promote condoms and female and male methods for STD and HIV protection.

Male involvement in family planning is essential to encourage men to assume responsibility for their sexual behaviour and to protect the health and well being of their partner, potential and existing offspring and the family as a whole (IPPF 1996). Family planning programmes should move away from the past tradition where services were geared only to women, and married ones at that to the establishment of some family planning and sexual and reproductive health services that are just for men.

This study looks at the factors that influence (inhibit or promote) the involvement and participation of men. It focuses on the social, demographic, economic and cultural factors that are crucial in determining or provoking the interest of men to accept and use family planning.

## **1.2 BACKGROUND OF THE STUDY**

The Republic of Kenya covers a total area of 582,646 km<sup>2</sup>. The country is situated on the Equator and borders Tanzania to the South, Uganda to the West, Sudan and Ethiopia to the North and the Somali Republic to the East.

Kenya is basically an agricultural country, and modern and traditional forms of land use are evident. Only about one-third of Kenya has enough rainfall for intensive agriculture and most of Kenya's population is concentrated on this productive area, to be found on the central highlands, the Lake Victoria region to the West and along the Coast. The rest of the country is generally arid and semi-arid and is mainly occupied by pastoral nomadic communities.

Ethnically Kenya is predominantly African in composition and is divided into over 40 ethnic communities. People of European and Asian origin are mainly found in urban areas where they are engaged in commercial activities. Kenya is thus a multi-racial society where people of different ethnic and religious backgrounds intermingle as they go about their daily tasks.

Kenya is divided into 8 provinces: Nairobi, Central, Coast, Eastern, Nyanza, Rift Valley, Western and North Eastern. According to the population census conducted in 1979 the total population of Kenya was 15.3m people. This increased to 21.4m in 1989 and 27.5million in 1995. By mid 1995, the population growth rate of Kenya was 3.0% and 2.4% in 1998 reflecting a substantial decline from the record growth rate of 3.8% in 1979. The observed growth rate during the 1979-1998 period has been mainly due to fertility decline.

The total fertility rate (TFR) was 8.1 children per woman in 1977/78 and this declined to 7.7 children in 1984, 6.7 children in 1989, 5.4 in 1993 and 4.7 in 1998. Although some variations exist between women depending on their area of residence, decreases in fertility were observed in all provinces.

The main force behind the fertility decline has been the increase in contraceptive use. The mostly widely used methods of contraceptives are injectibles (12 % of married women, the pill (9%) female sterilization (6%) and periodic abstinence (9%), IUD (3%) while over 1% are using condoms and 1% use Norplant.

According to the 1989 population census, Kenya's pop is youthful and 50% of the population is below 15 years. The 15-20 years age group constituted a further 20%. The proportion of the elderly people aged 64 years and above is only 4%. Owing to the youthful nature of the population, the dependency ratio is high. 73% of the population was seen to be living in rural areas despite increasing urbanization. The urban population increased from 15% in 1979 to 27% in 1989.

The country has also invested heavily in health infrastructure in order to meet the health needs of the population. Currently, there are 3,200 government and non-government health care institutions. Out of these 1,500 function as service delivery points for family planning (Republic of Kenya 1995). From 1980 to 1990 the number of doctors increased by over 100% to 4,000 (CBS 1992). In order to reduce the incidence of maternal mortality in rural areas, Kenya's health programme integrated traditional birth attendants (TBAs) into the health referral system. There are also more than 10,000 community based distribution workers in the country, who deliver non-clinical family planning services and disseminate information on family planning to local communities.

### **1.3 STATEMENT OF THE PROBLEM**

In Africa, although men play a key role in family decision making, many men do not participate in or support family planning programmes. According to UNFPA (1995) men have a stake in reproductive health through their multiple roles as sexual partners, husbands, fathers, family household members, community leaders and gatekeepers to health information and services. Men are involved in fertility and they have an important role to play in contraceptive decisions. In the male dominant cultures like in most African countries, men need to be educated on reproduction and contraception because in such societies men already have an encompassing involvement in decision pertaining to family and society.

According to IPPF (1995), organized population and family planning programmes have largely concentrated on women because arguably they (women) are the ones who 'become pregnant' most modern contraceptive methods are for females and consequently, family planning services have been offered in MCH/FP outlets. Many programme managers have also been reluctant to initiate male involvement programmes because of fear that men would be hostile to family planning, negative views regarding the efficacy of condoms, concerns about the cost of condoms relative to female methods as well as about the high cost of reaching the male audiences and inhibitions regarding vigorous promotion of vasectomy.

Many men in Africa do not participate in or support family planning programmes because they do not have enough information to enable them understand or appreciate the overall benefits of family planning. As a result certain misinformation, misconceptions and rumors exist about family planning and sexual and reproductive health in general. Yet every man has a responsibility and right to determine jointly with his partner, the most convenient, safe and suitable method of contraception.

Family planning programmes are now faced with new challenges such as the rising rates of STD and HIV infection, programme managers are increasingly recognizing that marginalising men is harmful to women's health as well. Given the dominant role of men in most African societies and their influence on women's contraceptive decision making decision and development programmes need to increasingly promote the idea of male involvement. This study will look at factors that have inhibited the acceptance and use of contraceptives by Kenyan men and will help in recommending ways in which male involvement in family planning can be promoted.

## **1.4 OBJECTIVES OF THE STUDY**

### **(a) Broad Objective**

The overall objective of this study is to identify demographic, socio-economic and socio-cultural factors that inhibit and enhance male participation and involvement in family planning.

### **(b) Specific Objectives**

1. To determine knowledge, attitudes and practices in family planning among Kenyan men.
2. To examine the relationship between demographic factors and the use of contraceptive among Kenyan men.
3. To find out the relationship between socio-economic and socio-cultural factors and contraceptive use by men in Kenya.

## **1.5 JUSTIFICATION OF THE STUDY**

Men have already been identified as a special category of the population that is currently under-served by reproductive health programmes. As a result men have not benefited from the information and education in those facilities, and they



have thus lagged behind women with regard to the knowledge of available contraceptive technology, their benefits and where to obtain them (Thumbi 1997). Men therefore have become easy victims of rumors and misinformation thus making them less supportive of family planning practice.

Male participation in fertility is critical to the wider acceptance of family planning. A third of the world's couples are currently estimated to be using a male dependent method such as condoms, vasectomy, withdrawal, periodic abstinence or other traditional method. According to the 1993 KDHS, of the 32.7% married users of any method, one in five rely on a male dependent method. This shows there is a growing worldwide recognition of the importance of male involvement in family planning.

However in Kenya there are wide discrepancies between knowledge and use. The determinants of these contraceptive rates discrepancies will be investigated in this paper. This will help in finding ways of encouraging high use of contraceptives as in other parts of the world. The study will also focus on ways of discouraging behaviours, beliefs and attitudes causing low use of contraception among Kenyan men.

There is also a large unmet need for family planning among men. As previous studies (DHS's) have shown, a quarter to a third of African husbands who do not want more children are still not practicing FP. Men also do not feel comfortable attending family planning clinics which are linked to MCH catering only to women. Male involvement in family planning is important for the success of both population and reproductive health programmes.

## **1.6 SCOPE AND LIMITATIONS OF THE STUDY**

The study targets 3407 males of ages 15-54 years, who responded to the 1998 KDHS. This is because different factors, demographic, cultural, social and economic, hinder men from contributing or being involved in family planning.

The focus of the study is on national data and as such it is possible some information will not reflect the individual or grassroots situation.

The KDHS studied only 15 districts in this country, therefore there is a possibility some information from the unstudied districts was left out or some of the information available might not be reflective of these districts.

The study will focus on knowledge and use of contraceptive among men in Kenya.

## CHAPTER TWO

### LITERATURE REVIEW AND STUDY DESIGN

#### 2.1 Introduction

For centuries, the role of men in fertility regulation was dominant through use of traditional birth spacing methods such as withdrawal and post partum abstinence. The condom which has been in use for at least 400 years continued male domination of fertility control, until 1960's and 1970's when the female contraceptive methods (the pill and Intra-Uterine Device - IUD) were discovered and made available for use. Since then in sub-Saharan Africa, family planning and reproductive health care research and interventions place a disproportionate emphasis on women and largely ignore the role of men (Adamchak and Mbizvo 1991). This has resulted to low participation of men in family planning.

Decisions regarding family planning knowledge, attitudes and practice are dominated by men as shown in a number of studies done in Africa. Adamchak and Mbizvo in 1991 in a study of family planning knowledge, attitudes and practices of 711 currently married men in Zimbabwe, showed that men alone or jointly with their wives, were involved in nearly 78% of decisions to use family planning.

Men's potentially positive role in family planning has often been ignored on the assumption that they hold negative attitudes towards birth control. But studies have shown that men have positive attitudes towards family planning. A study done by Ezeh in 1993, indicated that, African men have favourable attitudes towards family planning despite being a patriarchal society. However, this positive attitude has not been translated into high levels of contraceptive use due to social, demographic, cultural and economic factors compounded by the limited method choice available to men.

Several African countries have recognized the important role that men can play in planning and some of these countries e.g. Kenya, Zimbabwe and Ghana have initiated programmes to encourage male involvement through interventions to increase knowledge and interest among men.

A third of the world's couples practicing family planning, use a method that requires male participation co-operation. According to Ernest Feignaum (1978) recent studies have shown that men have much more interest in family planning and willing ness to practice it than they are given credit for. The four main family planning methods available for men include the condom, vasectomy, periodic abstinence and withdrawal and other traditional methods.

## **2.2 Demographic factors and contraceptive use**

Demographic factors like age, marital status and the number of living children determine male interest in family planning. In Kenya knowledge about contraceptives is quite high among all men young and old though use is higher among middle aged men. However, according to previous studies, age is not a determinant of family planning knowledge among Kenyan men. Men are likely to know at least one method irrespective of their age.

Marital statuses of men influence their knowledge and use of family planning. Though the difference may not be much, studies indicate that knowledge about contraceptives is almost universal in Kenya while use is slightly higher among married men than the young unmarried men and older men. Married men have indicated higher use of condoms but this does not indicate male involvement in family planning. The high prevalence of condom use has been due to increased HIV/AIDS awareness campaigns. Married men are increasingly using condoms to protect themselves against HIV/AIDS infections in extra-marital affairs rather than for family planning (Nzioka 1998).

The number of living children a man has should also determine whether a man uses family planning. Even with a few children (2-4) men are reluctant to adopt permanent methods of family planning like vasectomy and tubal ligation. The men cite fears of disasters as is common in this continent. Also the high infant and child mortality rates in some areas act as an impediment in the use of family planning. With the high death rates there is need for replacement and no need for birth control.

### **2.3 Socio-economic factors and contraceptive use.**

Kenya is divided into eight regions herein referred to as provinces namely, Nairobi, Central, Coast, Eastern, Nyanza, Rift Valley, Western and North Eastern. A lot of differences exist in the different regions due to their social and economic differences. Residents of these regions have different levels of knowledge of and use of contraceptives. Some regions are more developed economically than others e.g. the Central Province hence their levels are higher because they have easy access to information and services offered or available. In other regions where information and services are not readily available, the use of contraceptive has been quite low.

Education is an important factor in provoking male interest in family planning. Knowledge and use of contraceptive is higher among the more educated than the men with little or no education. In Kenya education is increasingly being treated as a replacement for land because of the changes in land ownership laws. Many people (parents) are now aware the cost of living is quite high and therefore parents who use contraceptives are able to raise the number of children they can afford to care for. This has become common knowledge among educated parents who are also willing to use contraceptives.

Place of residence and media exposure are the other socio-economic factors that can also influence men's knowledge and use of family planning.

African men living in urban areas are more likely to practice FP than those living in rural areas. People in urban areas have better access to family planning information and services thus their knowledge and use of contraceptives is higher than the men in rural areas. Men who live in urban areas are more likely to be more educated than those living in rural areas. This explains the higher practice of FP in urban areas than in rural areas.

## **2.4 Socio- cultural factors and contraceptive use**

The type of marriage, whether polygamous or monogamous and the people's religions are the socio-cultural factors that influence the knowledge and attitudes of African men towards FP. Family planning practice differs by type of marital union. In Kenya, Egypt and Cameroon as seen from earlier studies, practice is higher among men in monogamous unions than among those in polygamous unions. Men in polygamous unions marry many wives because they want another child and therefore they are less likely to practice family planning.

Most religious and other social groups promote members reproduction in order to perpetuate themselves. The main ones like Protestants, encourage believers in the Old: Testament, to 'go forth and multiply'. Most religious societies in Africa say that children inherit spiritual essence from ancestors. In such societies members of each generation preserve the taboos or special links to nature by naming an infant by determining which ancestor he/she resembles.

## **2.5 Knowledge, Attitudes and Practices of FP**

### **(a) Knowledge of Family Planning**

Most men have heard of modern contraceptive methods. The majority of African men know at least one family planning method, either modern or

traditional. According to Roudi in a number of countries such as Morocco, Egypt, Kenya, Rwanda and Zimbabwe, knowledge of FP among men is nearly universal. According to the 1998 KDHS 98.8% of the men know at least a modern or traditional method of family planning.

### **(b) Attitudes Towards FP**

In Kenya women are more likely than men to approve of FP. The gap between men and women's approval rates of FP is wider where the male approval rate is lower (Roudi 1996). Education is the strongest predictor of men's attitudes towards FP. Better educated men are more likely to approve of FP as men in monogamous marriages. Men who live in urban areas approve of FP more than their counterparts in rural areas as seen in other studies, though in Kenya there is almost no difference.

Men's attitude towards FP are more positive than assumed as shown in previous surveys (DHS).

### **(c) FP Practice**

Men can participate in family planning in 2 ways: by supporting their partner's decision to use FP and/or practicing a male method of FP themselves (condom, vasectomy, withdrawal or periodic abstinence). Men's support affects the choice, adoption, continuation and the correct use of female methods.

A wide gap exists between African couple's knowledge of an attitude toward and use of contraceptives. Although the majority of married couples in Africa know about FP, it is estimated that on average only about 22% of couples use either a modern or traditional method (Roudi 1996).

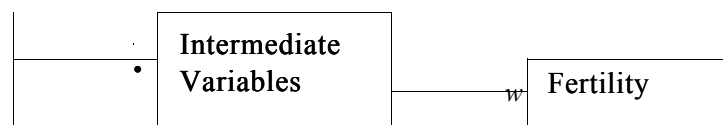
According to UNFPA (1995), a number of men have been motivated to undergo voluntary sterilization, a permanent method. Others are motivated to use temporary methods.

Traditional beliefs, customs and practices like sex preference (the desire to have sons) polygamy , old age security and naming practices have played a major role as an obstacle to FP practice (Fapohunda 1999).

## 2.6 Conceptual Model

Demographic, socio-economic and socio-cultural situations of the individual are likely to influence the fertility behaviour of men and inhibit or promote their knowledge and use of contraceptives.

- 1) Demographic factors
- 2) Socio-economic factors
- 3) Socio-cultural factors

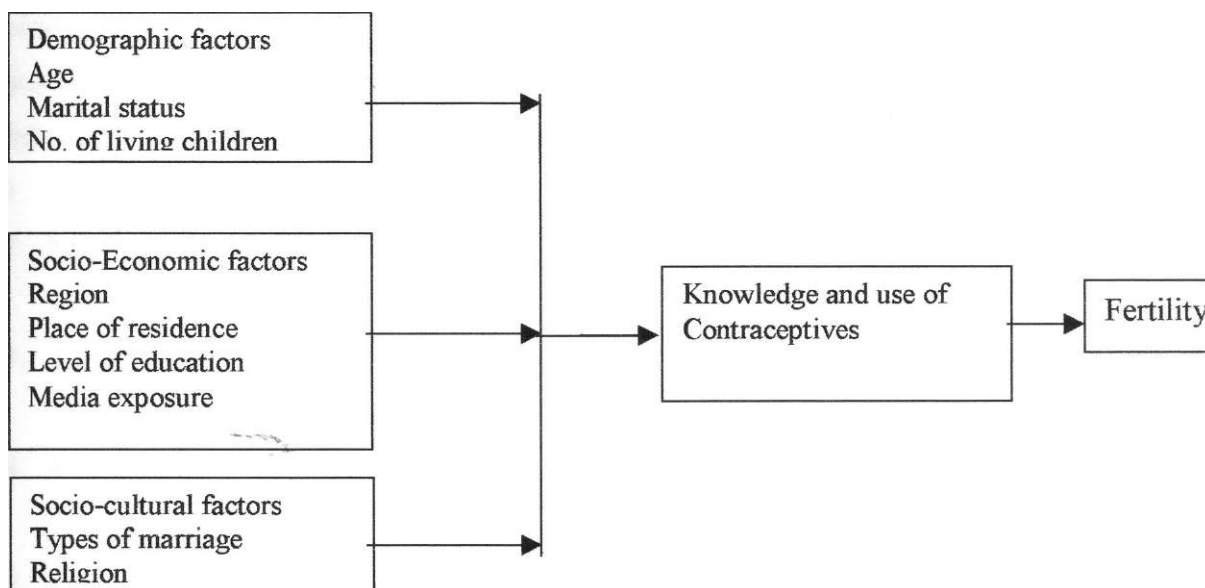




## 2.7 Operational Model

To operationalise the conceptual hypotheses they have been broken into measurable variables as shown below:-

Demographic factors	Age, marital status and living children
Socio-economic factors	Region, level of education, place of residence and media exposure
Socio-cultural factors	Type of marriage and religion
Intermediate variables	Knowledge of, ever use and current use of contraceptives



## 2.8 Variables used in the study

Independent variables	This is a variable upon which any prediction is based. The independent variables in this study are grouped into:-
Demographic factors	Age, marital status, and no. of children
Socio- economic factors	Region, level of education, place of Residence and media exposure
Socio- cultural factors	Type of marriage and religion
Dependent variables	This is a variable which is to predict any given study and the dependent variables in this study is contraceptive knowledge and use among men.

## 2.9 Operational Hypotheses

The operational formulation proposed will show how various demographic, socio-economic and socio-cultural factors or variables will affect men's knowledge and attitude change and consequent practice of family planning to reduce fertility. The following are operational hypotheses to be tested during data analysis:-

1. Age determines the knowledge and use of contraceptives by men.
2. Married men practice family planning more than the men who have never married.
3. The majority of men who practice family planning have reached their desired family size and do not want any more children.
4. Men living in urban areas are more likely to practice family planning than those living in rural areas.
5. Better educated men are more likely practice family planning or support their partners to practice family planning.
6. Men with access to all types of media (television, radio and newspapers) are more likely to know more methods and practice family planning.
7. Men in monogamous unions are likely to know and practice family planning than those in polygamous unions.
8. Protestant men know and practice modern family planning more than catholics and other religious groups.

## 2.10 Definition of key concepts

Age	Number of years lived
No. of living children	The total number of children one is currently having
Marital status	Whether one is currently married was formerly married or has never married
Media Exposure	Whether one reads newspapers, listens to Radio or watches television
Religion	One's belief/s
Region	Administrative areas herein referred to as provinces
Place of residence	Where one lives, either in an urban or rural area
Type of marriage	Type of marital union whether polygamous, Monogamous or not in any union (single)
Level of education	One's educational attainment.
Total fertility Rate	The average no. of children that would be born alive to a Woman (or group of women) during her lifetime
Unmet need	The term is used in the context of family Planning. A married man of reproductive age will be said to have an unmet need for family planning if he wants to either space or limit births and is not using any method of family planning.
Infant Mortality Rate	The number of deaths to infants under one of age per 1000 live births in a given year.

## **CHAPTER THREE**

### **DATA AND METHODOLOGY**

#### **3.1 Source of Data**

This study has used data obtained from the 1998 KDHS which was a national survey conducted by the NCPD(National Council for Population and Development) in collaboration with the CBS (Central Bureau of Statistics).

The survey covered 15 districts with the exception of sparsely-populated areas in the north of the country (North Eastern Province districts) which together comprise about 4% of the national population. The following districts were not included due to issues involving costs, logistics and security, Garissa, Mandera, Wajir, Isiolo, Marsabit, Turkana and Samburu.

Since all the districts could not be sampled, it was felt that reliable estimates for certain variables could be produced for the rural areas in 15 districts:- Bungoma, Kakamega, Kericho, Kilifi, Kisii, Machakos, Meru, Muranga, Nakuru, Nandi, Nyeri, Siaya, South Nyanza, Taita-Taveta and Uasin Gishu. Nairobi and Mombasa were also targeted. This resulted to oversampling at the District level which means the KDHS sample is not self weighting at the national level. Sample weights were used to compensate for the unequal probability of selection between geographically defined strata and weighted figures are used throughout this study.

The 1998 KDHS sample points were selected from a national master sample the National Sample Survey and Evaluation Programme (NASSEP - 3) which is maintained by the Central Bureau of Statistics from which 536 sample points were drawn.

Three types of questionnaires were used in the 1998 KDHS, the Household Questionnaire, the Women's Questionnaire and the Men's Questionnaire which was the focus of the study, covered many of the topics in the other questionnaires but excluded the detailed reproductive history and sections dealing with maternal and child health, maternal mortality and female circumcision which makes it consequently much shorter than the Women's questionnaire. The interviews were carried out in various local languages.

The analysis in this paper is based on the 3407 men between age 15-54 years who responded to the survey but the data used in this study is based on 2336 men due to the oversampling at the district level and therefore producing non-weighted data at the national level.

The study has also sought data from other supplementary information sources: - government publications, population reports, journals and magazines and other individuals and organisations.

### **3.2 Quality of Data**

The 1998 KDHS data is national in scope with the exclusion of only less than 4% of Kenya's population, therefore the focus of the study is on national data. However reliable estimates could not be produced from the KDHS for all the districts in the country which have increased in number from 48 to 75 since 1993. This therefore means that it is possible some information will not reflect the individual or grassroots situation.

Since the KDHS studied only 15 districts in this country, there is a possibility some information from the unstudied districts was left out or some of the information available might not be reflective of all districts considering that there exists cultural differences in these districts with diverse ethnic combinations.

The questionnaires were also reviewed, adapted and revised in a series of meetings which came up with the English questionnaire, which were translated into Kiswahili and nine of the most widely spoken languages: Kalenjin, Kamba, Kikuyu, Kisii, Luhya, Luo, Masai, Meru and Mijikenda. This was to ensure that the data collected was accurate and adequate for this kind of survey.

### **3.3 Methods of Data Analysis**

Descriptive and quantitative data analysis methods have been used in this study for representation of the information from the KDHS 1998.

#### **3.3.1 Frequency Distributions**

To summarise percentages frequencies of the background characteristics of the respondents have been used. These characteristics include age, marital status, number of children, region, place of residence (urban or rural), level of education, media exposure, type of marriage and religion.

#### **3.3.2 Cross Tabulations**

Cross tabulations have been used to determine the relationship among the variables, based on the column and row percentages which have left an indication whether there is a relationship between the variables. The dependent variable which is contraceptive use (i.e. knowledge of, ever use and current use) has been cross-tabulated with independent variables of age, marital status, living children, region, place of residence, level of education, media exposure, type of marriage and religion.

Chi -squares have been used to investigate the hypotheses. They have been used to find out what level of significance there is an association and also to show

whether there is a great statistically significant relationship between the independent and dependent variables.

## **CHAPTER FOUR**

### **CONTRACEPTIVE KNOWLEDGE AND USE AMONG KENYAN MEN**

#### **4.1 Background characteristics of respondents**

Men fall under a special category of the population that is currently under-served and inadequately targeted by family planning and reproductive health programmes. Research and interventions in these areas place a disproportionate emphasis on women and largely ignore the role of men. Although various studies have shown that African men have positive attitudes towards family planning despite being a patriarchal society, this attitude has not been translated into high levels of contraceptive use due to demographic, socio-economic and socio-cultural factors that act to limit use of contraceptives.

According to table 4.1.1 shown below, the study targeted men aged between 15-54 years. The highest number was aged between 25-34 years (34.8%) who are at the prime of their reproduction and the lowest number was among those aged 45 years and above (16.9%) who may not be using family planning at this age. 74% of the respondents were either currently or formerly married and 26% were not married. Men with up to 4 children and above were also targeted including those without children. All these demographic factors were taken into account to establish which category or groups of people/men know and use contraceptives and how these factors affect contraceptive use by men.

The respondents were also drawn from seven out of the 8 provinces of Kenya and these include Nairobi, Central, Coast, Eastern, Nyanza, Rift Valley, Western and North Eastern, whose population account for only 4% of the country's total population was not sampled. The highest number of respondents was drawn from rift valley Province (about 27%) which covers the larger part of the country while the lowest proportion was drawn from Nairobi province (only 7%). While about 55% of the respondents have attained primary education only 7.8% had no education which indicates most Kenyan men have



attained some levels of education. Almost 80% of the respondents were drawn from the rural areas while only 20% came from urban towns because majority of Kenyans live in rural areas. About 88% of the respondents listen to radio every week, 56% read newspapers once a week and only 31% watch television every week. This majority of Kenyan men receive family planning and reproductive health information through exposure to the media.

The socio-cultural factors were also considered in this in this study and correspondents were asked whether they are in any type of union by stating the number of wives or partners (if not married )they had. About 62% of the men are in monogamous unions while only 8% are in polygamous unions. This shows that more Kenyan men are preferring to either marry one wife or either marry later in life because of the economic strains involved in maintaining a larger family. Most men prefer to have smaller families, which they can easily maintain. Religion as another socio-cultural factor was also taken into account whereby over 55% of the men were reported to be Protestants, 35% were Catholics and only 10% belong to other religions.

The men also responded to questions about knowledge and use of contraceptives. From the study it was established that knowledge about contraceptive is almost universal (about 98%) among Kenyan men but use is still very low. Only about 31% of Kenyan men reported currently using modern methods and 9% (traditional methods). This shows there exists wide discrepancies between knowledge and use of contraceptives by men and some of these differences have been explained in this study.

The demographic, socio-economic and socio-cultural factors outlined above have been used to explain why these discrepancies have existed and the next chapter (Chapter 5) will be used to suggest ways (in the recommendations section) of reducing this gap and the way forward for planners and programmers.

**Table 4.1.1****Percentage Distribution of respondents by selected background characteristics.**

<b>CHARACTERISTICS</b>	<b>NUMBER</b>	<b>PERCENTAGE</b>
<b>Age</b>		
15-24	526	22.5
25-34	813	34.8
35-44	603	25.8
45-54	394	16.9
<b>Marital Status</b>		
Never married	602	25.8
Ever married	1734	74.2
<b>No. of living children</b>		
None	661	28.3
1 - 3	709	30.3
4+ children	965	41.3
<b>Region</b>		
Nairobi	171	7.3
Central	305	13.1
Coast	353	15.1
Eastern	308	13.2
Nyanza	302	12.9
Rift Valley	624	26.9
Western	273	11.7
<b>Education level</b>		
No education	182	7.8
Primary	1284	54.9
Secondary +	870	37.2
<b>Media Exposure</b>		
<b>1) Reads newspaper once a week</b>		
No	90	4.9
Yes	1353	57.9
<b>2) Watches TV every week</b>		
No	1617	69.2
Yes	712	30.5
<b>3) Listens to radio every week</b>		
No	284	12.2
Yes	2050	87.7
<b>Religion</b>		
Catholic	823	35.2
Protestant	1276	54.6
Other	236	10.1

<b>Knowledge of any method</b>		
Knows no method	28	1.2
Knows only traditional method	20	0.9
Knows modern method	2288	97.9
<b>Ever use of any traditional method</b>		
No	1874	80.2
Yes	462	19.8
<b>Ever use of any modern method</b>		
No	1161	49.7
Yes	1175	50.3
<b>Currently using modern method</b>		
No	1615	69.1
Yes	721	30.9
<b>Currently using traditional method</b>		
No	1892	81.0
Yes	444	9.0
<b>TOTAL</b>	<b>2336</b>	<b>100.0</b>

Source: 1998 Kenya demographic and Health Survey Data

Note: Not stated/missing category accounts for the balance where total percentages do not add up to 100.

#### **4.2 Ever use of any traditional method by respondents**

According to table 4.2.1 shown below, demographic characteristics have been related to determine what affects ever use of traditional methods of family planning by respondents. Ever use of any traditional method was found to be higher among those men aged between 45-54 years (24%) and lowest among those aged between 15-24 years (14%) because these methods are not popular among the young. About 22% of those men who have ever married and those with more than 4 children have ever used a traditional method as opposed to only about 13% of those who have never married and those with no children. This shows that the older men are more conversant with and also appreciate traditional methods of family planning more than the younger generations.

**Table 4.2.1****Ever use of traditional method and demographic characteristics**

CHARACTERISTICS	EVER USE OF ANY TRADITIONAL (PERCENTAGE)				CHI-SQUARE TEST
	NO	YES	TOTAL	NUMBER	
<b>Age</b>					
15-24	85.6	14.4	100	526	Value - 16.399 Df - 3 Level of significance - 0.001
25-34	80.6	19.4	100	813	
35-44	78.1	21.9	100	603	
45-54	75.6	24.4	100	394	
<b>Marital Status</b>					
Never married	87.4	12.6	100	602	Value-26.152 Df - 1 Level of Significance - 0.000
Ever married	77.7	22.3	100	1734	
<b>No. of living children</b>					
None	86.2	13.8	100	661	Value-22.551 Df - 2 Level of significance - 0.000
1-3 children	79.4	20.6	100	709	
4+ children	76.8	23.2	100	965	
<b>TOTAL</b>	<b>80.2</b>	<b>19.8</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya Demographic and Health Survey Data

Note : Not stated/missing category accounts for the balance where total percentages do not add up to 100.

Table 4.2.2. shown below, depict the findings of the socio-economic factors (region, education level, place of residence and media exposure) and how they affect ever use of traditional methods. Ever use of traditional method was highest among men in Eastern Province (36%) and lowest in Nyanza province (only 7%). Those with no education and those in living rural areas also reported ever using traditional methods more than the rest of the men in these categories. This trend could be associated with the limited information about modern family planning that reach people who are not educated and living in rural areas because of the physical distance and the limited channels of communication among these categories of people. Only about 20% of the men who are exposed to all channels of media (television, radio and newspapers) reported ever using a traditional method.

**Table 4.2.2**

**Ever use of traditional method and socio-economic characteristics**

CHARACTERISTICS	EVER USE OF TRADITIONAL (PERCENTAGE)				CHI-SQUARE TEST
	NO	YES	TOTAL	NUMBER	
<b>Region</b>					
Nairobi	87.1	12.9	100	171	Value - 128.042 Df - 6 Level of significance - .000
Central	87.2	12.8	100	305	
Coast	81.0	19.0	100	353	
Eastern	64.0	36.0	100	308	
Nyanza	84.0	11.6	100	302	
Rift Valley	72.9	27.0	100	624	
Western	93.0	7.0	100	273	
<b>Education level</b>					
No education	72.5	27.5	100	182	Value - 12.428 Df - 2 Level of significance -0.002
Primary	79.3	20.7	100	1284	
Secondary +	83.2	16.8	100	870	
<b>Place of residence</b>					
Urban	86.9	13.1	100	480	Value - 16.851 Df - 1 Level of significance -0.000
Rural	78.5	21.5	100	1856	
<b>Media Exposure</b>					
<b>1) Reads Newspaper</b>					
<b>Once a week</b>					Value 21.383 Df - 1 Level of significance - 0.000
No	75.7	24.3	100	980	
Yes	83.4-	16.6	100	1353	
<b>2) Watches TV every</b>					
<b>week</b>					Value-2.229 Df - 1 Level of significance - 0.135
No	79.3	20.7	100	1617	
Yes	82.0	18.0	100	712	
<b>3) Listens to radio</b>					
<b>every week</b>					Value - 0.687 Df - 1 Level of significance - 0.407
No	82.0	18.0	100	284	
Yes	80.0	20.0	100	2050	
<b>TOTAL</b>	<b>80.2</b>	<b>19.8</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya Demographic and Health Survey Data

Note Not stated/missing category account for the balance where total percentages do not add up to 100

According to table 4.2.3 below men in either monogamous or polygamous unions reported higher ever use of a traditional methods (about 22%) and also among the Catholics (23%) who associate themselves with use of natural family planning as opposed to modern methods of family planning. The Protestants reported lowest use (about 18%) of ever use of traditional methods.

**Table 4.2.3**

**Ever use of traditional method and socio-cultural characteristics**

CHARACTERISTICS	EVER USE OF TRADITIONAL METHOD (PERCENTAGES)				CHI-SQUARE TEST
	NO	YES	TOTAL	NUMBER	
<b>No. wives, partners</b>					
Single	85.6	14.4	100	699	Value - 17.756 Df - 2 Level of significance - 0.000
Monogamous	77.9	22.1	100	1497	
Polygamous	78.7	21.3	100	178	
<b>Religion</b>					
Catholic	77.0	23.0	100	823	Value-9.011 Df - 2 Level of significance - 0.011
Protestant	82.4	17.6	100	1276	
Other	79.7	20.3	100	236	
<b>TOTAL</b>	<b>80.2</b>	<b>19.8</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya Demographic and Health Survey Data

Note Not stated/missing category accounts for the balance where total percentages do not add up to 100

**4.3 Ever use of any modern method by respondents**

Of all the respondents, over 50% reported ever using at least one modern method of family planning while only about 49% have never used. This shows that modern methods are more acceptable by men as compared to traditional methods where only about 20% men reported ever using.

From table 4.3.1 below, it was found out that all categories of men have ever used a modern method regardless of their age though use is highest (55.5%) among those aged between 25-34 years (who are in their high reproductive ages) and lowest (37.6%) among men aged between 45-45 years. The older people may not be needing to practice family planning as they are past active reproduction ages. Ever use of modern methods is also higher among those men who have never married (56%) and those with no children or up

to 3 children (54%). These are young people who may be appreciating the advantages of a smaller family and hence practice modern family planning.

**Table 4.3.1**

**Ever use of any modern method and demographic characteristics**

CHARACTERISTICS	EVER USE OF MODERN METHODS PERCENTAGES				CHI-SQUARE TEST
	NO	YES	TOTAL	NUMBER	
<b>Age</b>					
15-24	46.2	53.8	100	526	Value-37.557 Df— 3 Level of significance -0.000
25-34	44.5	55.5	100	813	
35-44	51.4	48.6	100	603	
45-54	62.4	37.6	100	394	
<b>Marital Status</b>					
Never married	44.4	55.6	100	602	Value-16.560 Df- 1 Level of significance- 0.000
Ever married	51.6	48.4	100	1734	
<b>No. of living children</b>					
None	46.4	53.6	100	661	Value -15.356 Df- 2 Level of Significance -0.000
1 - 3 children	46.1	53.9	100	709	
4+ children	54.5	45.5	100	965	
<b>Total</b>	49.7	<b>50.3</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note : Not stated/missing category accounts for the balance where total percentages do not add up to 100.

Table 4.3.2 below shows the relationship between socio-economic characteristics and how they affect use of modern methods by Kenyan men. In Nairobi and Central regions of Kenya, men reported higher ever use of modern methods (about 64%). Those men with secondary education and above had the highest (64%) and those living in urban areas (62%). This shows that those men have better access to information and service on family planning. Between 50% and 67% of the men who have ever used modern methods have exposure to media and this enhances their source of information and therefore practice of modern ways of family planning.

**Table 4.3.2****Ever use of modern methods and socio-economic characteristics**

CHARACTERISTICS	EVER USE OF MODERN METHODS (PERCENTAGES)				CHI-SQUARE TESTS
	NO	YES	TOTAL	NUMBER	
<b>Region</b>					
Nairobi	36.6	63.7	100	171	Value-66.553 Df- 6 Level of significance- 0.000
Central	36.1	63.9	100	305	
Coast	54.4	45.6	100	353	
Eastern	42.5	57.5	100	308	
Nyanza	59.3	40.7	100	302	
Riil Valley	52.2	47.8	100	624	
Western	59.0	41.0	100	273	
<b>Education level</b>					
No Education	78.6	21.4	100	182	Value- 135.673 Df- 2 Level of significance- 0.000
	54.7	45.3	100	1284	
Secondary +	36.3	63.7	100	870	
<b>Place of Residence</b>					
Urban	37.9	62.1	100	480	Value - 33.356 Df- 1 Level of Significance- 0.000
Rural	52.7	47.3	100	1856	
<b>Media Exposure</b>					
1) Reads N/paper once a week					Value-146.252 Df- 1 Level of Significance - 0.000
No	64.4	35.6	100	980	
Yes	39.0	61.0	100	1353	
2) Watches TV every week					Value - 104.064 Df- 1 Level of significance- 0.000
No	56.6	43.6	100	1617	
Yes	33.7	66.3	100	712	
3) Listens to radio every week					Value-53.671 Df- 1 Level of significance- 0.000
No	70.1	29.9	100	284	
Yes	46.9	53.1	100	2050	
<b>Total</b>	<b>49.7</b>	<b>50.3</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note : Not stated/missing category account for the balance where total percentages do not add up to 100.

Over 50% of those who are single and in monogamous unions reported ever using of modern method while only 34% in polygamous unions have ever used because most of these men want to have more children and therefore do not see the need of limiting births. Protestant men reported higher use of modern methods compared to Catholics who do not readily accept modern methods of family planning and other religions and traditionalists who may prefer other ways other than modern family planning methods. This is the picture depicted in table 4.3.3 below: -



**Table 4.3.3****Ever use of modern methods and socio-cultural characteristics**

CHARACERJSTICS	EVER USE OF MODERN METHODS (PERCENTAGES)				
	NO	YES	TOTAL	NUMBER	CHI-SQUARE TESTS
<b>No. of wives, partners</b>					
Single	46.1	53.9	100	699	Value- 22.017 Df -2 Level of significance - 0.000
Monogamous	49.5	50.5	100	1457	
Polygamous	65.7	34.4	100	178	
<b>Religion</b>					
Catholic	50.3	49.7	100	823	Value-6.256 Df - 2 Level of significance -0.044
Protestant	48.0	52.0	100	1276	
Other	56.8	43.2	100	236	
<b>TOTAL</b>	49.7	<b>50.3</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note : Not stated/missing category account for the balance where total percentages do not add up to 100.

#### 4.4 Current use of any traditional method by respondents

The study found out that out of the total number of men who responded, only 19% reported to be using a traditional method currently while 81% are not.

From table 4.4.1 over 20% those men aged between 35-44 years, who have ever married and have children are currently using a traditional method as opposed to the young unmarried men without children who may not be well informed about these methods. These are the demographic factors influencing current use of traditional methods of family planning.

**Table 4.2.1****Currently using traditional methods and demographic characteristics**

CHARACERISTICS	CURRENTLY USING TRADITIONAL METHOD (PERCENTAGE)				CHI-SQUARE TESTS
	NO	YES	TOTAL	NUMBER	
<b>Age</b>					
15-24	82.5	17.5	100	526	Value-7.215 Df- 3 Level of significance- 0.065
25-34	80.7	19.3	100	813	
35-44	77.9	22.1	100	603	
45-54	84.3	15.7	100	394	
<b>Marital Status</b>					
Never married	85.0	15.0	100	602	Value - 8.670 Df- 1 Level of significance- 0.003
Ever married	79.6	20.4	100	1734	
<b>No. of living children</b>					
None	84.9	15.1	100	661	Value-9.159 Df- 2 Level of Significance- 0.010
1 - 3 children	79.8	20.2	100	709	
4+ children	79.2	20.8	100	965	
<b>TOTAL</b>	<b>81.0</b>	<b>19.0</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note : Not stated/missing category account for the balance where total percentages do not add up to 100.

The socio-economic factors, which influence the current use of any traditional method, are depicted in the findings in table 4.4.2 shown below. Eastern province again showed the highest number (37%) of men who are currently using a traditional method while the lowest is in Western region (only 6%). About 20% of the men with some education and living in rural areas reported currently using a traditional method. The lowest reported was among the men living in urban areas (only 12%) less than 19% of all men exposed to all types of media reported currently using traditional methods because these methods are not advertised or promoted through the media.

**Table 4.4.2**

**Currently using a traditional method and socio-economic characteristics**

CHARACTERISTICS	EVER USING TRADITIONAL METHOD			PERCENTAGES)	
	NO	YES	TOTAL	NUMBER	CHI-SQUARE TESTS
<b>Region</b>					
Nairobi	84.8	15.2	100	171	Value - 139.089 D f - 6 Level of significance -0.000
Central	88.2	11.8	100	305	
Coast	84.4	15.6	100	353	
Eastern	63.3	36.7	100	308	
Nyanza	88.4	11.6	100	302	
Rift Valley	73.9	26.1	100	624	
Western	94.1	5.9	100	273	
<b>Education level</b>					
No Education					Value - 0.856 D f - 2 Level of significance -0.652
Primary	83.5	16.5	100	82	
Secondary +	80.9	19.1	100	1284	
	80.6	19.4	100	870	
<b>Place of Residence</b>					
Urban					Value -18.812 D f - 1 Level of Significance- 0.000
Rural	87.9	12.1	100	480	
	79.2	20.8	100	1856	
<b>Media Exposure</b>					
<b>1) Reads Newspaper once a week</b>					Value-33.494 D f - 1 Level of Significance- 0.062
No	79.2	20.8	100	980	
Yes	82.3	17.7	100	1353	
<b>2) Watches TV every Week</b>					Value-0.238 D f - 1 Level of significance 0.625
No	81.2	18.8	100	1617	
Yes	80.3	19.7	100	712	
<b>3) Listens to radio every week</b>					Value - 5.876 D f - 1 Level of significance - 0.015
No	86.3	13.7	100	284	
Yes	80.2	19.8	100	2050	
<b>Total</b>	<b>81.0</b>	<b>19.0</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note Not stated/missing category account for the balance where total percentages do not add up to 100.

Current use of traditional methods is quite low in all types of unions. Those men in monogamous unions showed a slightly higher use (22%) compared to the other groups of people because they would want to limit the number of children they could have and to have the numbers they can manage to bring up comfortably. The polygamous men reported over 18% of use of traditional methods, which include the ancient methods, which have thrived for a long time and justify the existence of polygamous unions like

abstinence during breast-feeding. About 24% of Catholics are currently using a traditional methods as this is the only acceptable method through natural family planning. This is shown below in table 4.4.3.

**Table 4.4.3**

**Currently using a traditional method and socio-cultural characteristics**

CHARACERISTICS	CURRENTLY USING TRADITIONAL METHOD (PERCENTAGES)				CHI-SQUARE TESTS
	NO	YES	TOTAL	NUMBER	
<b>No. of wives, partners</b>					
Single	86.1	13.9	100	699	Value- 18.089
Monogamous	78.4	21.6	100	1457	Df -2
Polygamous	81.5	18.5	100	178	Level of significance - 0.000
<b>Religion</b>					
Catholic	76.4	23.6	100	823	Value-19.239
Protestant	82.8	17.2	100	1276	Df -2
Other	86.9	13.1	100	236	Level of significance - 0.000
<b>TOTAL</b>	<b>81.0</b>	<b>19.0</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note Not stated/missing category account for the balance where total percentages do not add up to 100.

#### 4.5 Current use of modern methods by respondents

Currently, men who reported using at least one modern method were 31%. The highest use is among men aged between 25 - 44 years regardless of whether they are married or not and also those with children. These are the men who are well informed about modern family planning and also appreciate the advantages of a smaller family. This is shown below in table 4.5.1.

**Table 4.5.1****Current use of modern methods and demographic characteristics**

CHARACERISTICS	CURRENTLY USING TRADITIONAL METHOD (PERCENTAGE)				CHI-SQUARE TESTS
	NO	YES	TOTAL	NUMBER	
<b>Age</b>					
15-24	73.0	27.0	100	526	Value - 13.678 Df - 3 Level of significance -0.003
25-34	65.9	34.1	100	813	
35-44	66.8	33.2	100	603	
45-54	74.1	25.9	100	394	
<b>Marital Status</b>					
Never married	69.6	30.4	100	602	Value -0.083 Df - 1 Level of significance- 0.774
Ever married	69.0	31.0	100	1734	
<b>No. of living children</b>					
None	73.5	26.5	100	661	Value-8.461 Df - 2 Level of Significance - 0.15
1 - 3 children	67.0	33.0	100	709	
4+ children	67.7	32.3	100	965	
<b>TOTAL</b>	<b>69.1</b>	<b>30.9</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note Not stated/missing category account for the balance where total percentages do not add up to 100.

*m*

The socio-economic factors that influence current use of modern methods are shown in Table 4.5.2 summarized below. The highest use (42%) was reported in Central and Eastern regions of Kenya while Nyanza province had the lowest number of users (19%), because of the high infant and child deaths and therefore the need for replacement. Men with higher education also reported using modern methods currently compared to those with low education. The prevalence rates are also high among the urban men which shows that better educated men and those living in urban areas have better access to family planning information and services. These men also have higher exposure to all kinds of media, as shown in table 4.5.2 below:-

**Table 4.5.2****Current use of modern methods and socio-economic characteristics**

CHARACTERISTICS	EVER USING TRADITIONAL METHOD (PERCENTAGES)				CHI-SQUARE TESTS
	NO	YES	TOTAL	NUMBER	
<b>Region</b>					
Nairobi	61.4	38.6	100	171	Value-72.512 Df- 6 Level of significance- 0.000
Central	58.4	41.6	100	305	
Coast	77.6	22.4	100	353	
Eastern	58.1	41.9	100	308	
Nyanza	80.8	19.2	100	302	
Rift Valley	72.0	28.0	100	624	
Western	68.1	32.9	100	273	
<b>Education level</b>					
No Education	86.3	13.7	100	182	Value - 76.469 Df- 2 Level of significance 0.000
Primary	73.4	26.6	100	1284	
Secondary +	59.2	40.8	100	870	
<b>Place of Residence</b>					
Urban	61.3	38.8	100	480	Value - 17.604 Df— 1 Level of Significance 0.000
Rural	71.2	28.8	100	1856	
<b>Media Exposure</b>					
<b>1) Reads Newspaper once a week</b>					Value - 96.975 Df- 1 Level of Significance -0.000
No	80.2	19.8	100	980	
Yes	61.1	38.9	100	1353	
<b>2) Watches TV every Week</b>					Value -102.908 Df- 1 Level of significance -0.000
No	75.6	24.4	100	1617	
Yes	54.5	45.5	100	712	
<b>3) Listens to radio every week</b>					Value-44.405 Df- 1 Level of significance - 0.000
No	86.3	13.7	100	284	
Yes	66.8	33.2	100	2050	
<b>Total</b>	<b>69.1</b>	<b>30.9</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note : Not stated/missing category account for the balance where total percentages do not add up to 100.

Over 33% of men in monogamous unions and those who are Protestants reported currently using modern methods higher than those not in any union or in polygamous marriages and Catholics and other religions. This is summarized in Table 4.5.3 below-

**Table 4.5.3****Current use of modern methods and socio-cultural characteristics**

CHARACERISTICS	CURRENTLY USING TRADITIONAL METHOD (PERCENTAGES)				
	NO	YES	TOTAL	NUMBER	CHI-SQUARE TESTS
<b>No. of wives, partners</b>					
Single	71.8	28.2	100	699	Value- 15.071
Monogamous	66.6	33.2	100	1457	Df -2
Polygamous	79.2	20.8	100	178	Level of significance - 0.001
<b>Religion</b>					
Catholic	71.6	28.4	100	823	Value - 7.332
Protestant	66.8	33.2	100	1276	Df- 2
Other	73.3	26.7	100	236	Level of significance- 0.026
<b>TOTAL</b>	<b>69.1</b>	<b>30.9</b>	<b>100</b>	<b>2336</b>	

Source : 1998 Kenya demographic and Health Survey Data

Note : Not stated/missing category account for the balance where total percentages do not add up to 100.

**4.6 Knowledge of any method by respondents**

Men were found to know at least a traditional or a modern method of family planning therefore knowledge is almost universal. Over 98% of men know at least one method either traditional or modern. Men of all ages young and old have a very high knowledge of contraceptives with the highest knowledge among the young aged between 15-24 years (99%) and the level of knowledge goes down with increasing of age. It is slightly lower with men 45 years and above. It is equally high (98.8%) regardless of the marital status of the men and even higher among men with few children, 1-3 (99.2%) as shown in table 4.6.1 below:-

**Table 4.2.1****Knowledge of any method and demographic characteristics**

CHARACERISTICS	KNOLEDGE OF ANY METHOD			
	NO	YES	TOTAL	NUMBER
<b>Age</b>				
15-24	0.8	99.2	100	526
25-34	1.1	98.9	100	813
35-44	1.2	98.8	100	603
45-54	2.0	97.9	100	394
<b>Marital Status</b>				
Never married	1.2	98.8	100	602
Ever married	1.2	98.8	100	1734
<b>No. of living children</b>				
None	1.2	98.8	100	661
1 - 3 children	0.8	99.2	100	709
4+ children	1.5	98.5	100	965
<b>TOTAL</b>	<b>1.2</b>	<b>98.8</b>	<b>100</b>	<b>2336</b>

Source : 1998 Kenya demographic and Health Survey Data

Note Not stated/missing category account for the balance where total percentages do not add up to 100.

The socio-economic characteristics show that knowledge is universal in Nairobi region which is the major city and it is equally high in other regions (over 99%) except central province (96%) which is classified as mostly rural region. Table 4.6.2 also shows that knowledge is high among those with some or higher education (over 98%) while it is lower among those men with no education and this accounts for the limited exposure or information on family planning. Urban and rural areas also reported high knowledge although it is slightly higher in urban than rural areas due to the physical distance involved in acquiring this information. The media has also played major role in promoting family planning because a lot of men who are exposed also reported high knowledge as shown in the table below:-



**Table 4.2.1****Knowledge of any method and socio-economic characteristics**

CHARACTERISTICS	KNOWLEDGE OF ANY METHOD (PERCENTAGE)		TOTAL	NUMBER
	NO	YES		
<b>Region</b>				
Nairobi	0.0	100.0	100	171
Central	4.3	95.7	100	305
Coast	0.6	99.4	100	353
Eastern	0.6	99.4	100	308
Nyanza	1.0	99.0	100	302
Rift Valley	1.0	99.0	100	624
Western	0.7	99.3	100	273
<b>Education level</b>				
No Education	3.3	96.7	100	182
Primary	1.4	98.6	100	1284
Secondary +	0.5	99.5	100	870
<b>Place of Residence</b>				
Urban	0.2	99.8	100	480
Rural	1.5	98.5	100	1856
<b>Media Exposure</b>				
1) <b>Reads Newspaper once a week</b>				
No	2.0	98.0	100	980
Yes	0.6	99.4	100	1353
2) <b>Watches TV every Week</b>				
No	1.5	98.5	100	1617
Yes	0.4	99.6	100	712
3) <b>Listens to radio every week</b>				
No	3.5	96.5	100	284
Yes	0.9	99.1	100	2050
<b>Total</b>	<b>1.2</b>	<b>98.8</b>	<b>100</b>	<b>2336</b>

Source : 1998 Kenya demographic and Health Survey Data

Note Not stated/missing category account for the balance where total percentages do not add up to 100.

While knowledge is quite high among the singles (those not in any union) and are sexually active and those in monogamous unions (over 98.8%) it is slightly lower among the polygamous men who may not need family planning information because they would prefer to have more children. Knowledge is also higher among the Protestants who show more interest in both modern and traditional methods unlike the Catholics who only identify with natural family planning and other religious groups who may even be

traditionalists and therefore have limited knowledge of modern family planning. These factors are summarized in table 4.6.3 below:

**Table 4.6.3**  
**Knowledge of any method and socio-cultural factors**

CHARACTERISTICS	KNOWLEDGE OF ANY METHOD (PERCENTAGES)			
	NO	YES	TOTAL	NUMBER
<b>No. of wives, partners</b>				
Single	1.1	98.9	100	699
Monogamous	1.0	99.0	100	1457
Polygamous	2.8	97.2	100	180
<b>Religion</b>				
Catholic	1.6	98.4	100	823
Protestant	0.8	99.2	100	1276
Other	2.1	97.9	100	236
<b>TOTAL</b>	<b>1.2</b>	<b>98.8</b>	<b>100</b>	<b>2336</b>

Source • 199&Keuya demographic aud Health Survey Date

Note Not stated/missing category account for the balance where total percentages do not add up to 100.

## **CHAPTER FIVE**

### **SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 Introduction**

The main objective of the study was to identify demographic, socio-economic and socio-cultural factors that inhibit and enhance male participation and involvement in family planning. The study examined the factors that influence the use of contraceptives by men in Kenya. The main source of data is the Kenya Demographic and Health Survey (KDHS) 1998. Cross-tabulations and chi squares were the main statistical methods of data analysis that were utilized in this study.

#### **5.2 Summary of Findings and Conclusions**

From the study it was established that despite the high knowledge about family planning, men were still reluctant to accept and practice family planning, despite the fact that Kenyan men play a critical role in family decisions. Men through their multiple roles as sexual partners, husbands, fathers, family household members, -community leaders and gatekeepers to health information and services, have a very important role to play in contraceptive.

##### **5.2.1 Summary of Findings and Conclusions on Demographic Factors**

Men of all ages know of family planning. Knowledge has been seen to be almost universal. Except for the men who are 45 years and above, those who are below this age have over 98% knowledge of either a modern or traditional method of family planning. Ever use and current use of modern methods was also high among those below the age of 45 years. Use of traditional methods is more popular among the older men because education on modern methods of family planning

does not target this group of people. Most of them have also acquired their desired number of children and therefore do not need this information. This satisfies hypothesis 1 in which the middle aged men practice family planning more compared to the other age groups. These men are at the prime of their reproduction and therefore need to limit the sizes of their families. Use of modern methods is highest after the age of 24 years and goes down sharply after 35 years and above. This also supports and agrees with hypothesis number 1.

Although knowledge of any method either modern or traditional is over 98% for all men either never married, currently or formerly married, use is still very low. Those who have never married reported using either a modern or traditional method almost at the same level as those who are either currently married used family planning in order to regulate their fertility in their families and also men now realize the importance of a smaller family which they can support and take care of. For those who have never married have a higher ever use of modern methods to protect themselves from getting children or the consequences of abortion thus the need to protect themselves and their partners from getting pregnant. This also agrees with hypothesis 2.

Knowledge has remained high among all men with or without children but use differs depending on the number of children one has. Those with more than 4 children use traditional methods more than the ones without or with less than 4 children because they have reached their desired family size and do not want any more children, and this support the hypothesis 3. Those with fewer or no children practice modern family planning because they have access to this information and need to regulate fertility to achieve their desired family sizes.

### **5.2.2 Summary of Findings and Conclusions on Socio-Economic Factors.**

The study, which was carried out in 7 out of the 8 provinces of Kenya, showed that knowledge about family planning is almost universal (over 99%) in all the other provinces except central province (95.7%). Although use of both modern and traditional methods is low as compared to the general knowledge. Men have attributed the low use of contraceptives to the widespread belief that Family Planning is women's business and this notion accounts for lack of concern.

Most men also lack information on the advantages of Family Planning. As a result there have been misconceptions regarding the contraceptive methods and especially use of condoms, which accounts for their limited use in rural areas and among persons of lower educational statuses. Use of contraceptives is also higher among those with higher education and among those in formal employment. This is because most of those men have access to all types of media (television, radio and newspaper) and therefore have access to Family Planning information. Thus they are more likely to practice family planning or support their partners to practice family planning. These findings support objective 2 and satisfy hypotheses 4, 5 and 6.

### **5.2.3 Summary of Findings and Conclusions on Socio-Cultural Factors.**

Misconceptions emanating from local beliefs and practices that have flourished due to the lack of adequate proven information, divergent preference for the number and composition of children, disparities among spouses in the cost and benefits of children, low education levels, women's dependency on their husbands, persistence of beliefs and practices that promote male domination such as naming practices pressure from parents-in-law and polygamy and gender division of labour which promotes women's reproductive roles at the expense of

their productive roles, have greatly influenced use of family planning by men in Kenya.

This accounts for the low use of contraceptives among those in polygamous unions who may not want to be associated with some of these traditional/cultural beliefs and practices. The Catholics who all along have identified themselves with the natural family planning (NFP) practice these methods more than the modern methods while the Protestants and the other religions groups practice both the modern and traditional methods. Use of contraceptives has remained low in all religious groups because most religious and social groups promote members reproduction in order to perpetuate themselves. This however supports the cultural beliefs and practices that prevail in most of the African societies that are predominantly pro-natalists. Thus despite the high knowledge of contraceptives, use has remained very low which is in line with objective 3 and supports hypotheses 7 and 8.

## **5.3 RECOMMENDATIONS**

### **5.3.1 Introduction**

Although men play a key role in family decision making, many men do not participate in or support Family Planning programs, because they do not have enough information to enable them understand or appreciate the overall benefits of family planning. A number of obstacles have also been identified which include gender gaps in access to resources, poor male access to reproductive information and services and operational problems regarding services delivery (i.e. range of services provided, the lack of choice, space, privacy, comfort, convenience, confidentiality, skills, personnel, supplies and poor provider behavior). Recommendations for addressing some of these obstacles are discussed below.

### **5.3.2 Recommendations for policy makers**

There is need for widespread education on the advantages of family planning and level out the misconceptions that have long existed among Kenya men. These misconceptions are engendered by the lack of factual information about Family Planning .Men hold a number of beliefs regarding Family Planning which are obstacles to their adopting it themselves or supporting the use of Family Planning by their partner. Therefore there is need for policy and programs that would increase education and awareness of the role of family planning among men in communities, by

1. Emphasizing that family planning is for everyone women, men and adolescents.
2. Large scale public awareness campaigns to change community perceptions about Family Planning, and
3. Engage men in the formulation and implementation of community based reproductive health education programs including HIV/Aids.

These education programs should mainly focus on the young whose attitudes are less rigid and also stress on the importance of a smaller family especially during the current economic hardship facing the country.

Population education needs to be introduced for both in school youth and out of school men. The reproductive health technologies and family planning should be advertised through the mass media and village level channels such as chiefs' barazas and funerals.

Programs should aggressively seek ways to expand service provision to men. Poor access to information and services should be addressed reducing the physical distances to these services and also reducing the gender disparity in accessing reproductive resources. Family Planning services have been provided in maternal and child health (MCH) clinics. Men should be included in programs targeted towards improving women's reproductive health by encouraging them to

seek STDs treatment in clinics where they can also be educated about ways to protect themselves from diseases and unwanted pregnancies.

Policies that promote gender equity by increasing women's access to high education, specialized training and economic opportunities which will reduce women's dependence on their partners and improve wife's ability to negotiate partner cooperation and collaboration in the utilization of reproductive health services should be enhanced. Greater focus on women's access to higher education, income generation and adult education will improve skills and knowledge of individuals and couples.

Appropriate programmes should be put in place to enhance men's access to reproductive resources and increase their involvement as gatekeepers of women's health. Male-friendly services should be offered and these will meet male clients expectations. The programmes should offer services that will guarantee client's confidentiality, privacy comfort and convenience as well as good provider- client interaction.

### **5.3.3 Recommendation for Further Research**

There is need for further research to be done on demographic, social, economic and cultural factors and how they affect contraceptive use by men in Kenya and how men can be encouraged to take responsibility of their own and also partners health. The results should establish why despite the high knowledge, use is still very low as compared to other parts of the world.

Primary data needs to be collected at the grassroots level and if possible, a nationwide survey carried out to get the true picture on the factors influencing the use of contraceptives by men in Kenya. Some of the areas that were not covered by the KDHS were only assumed to be having the same characteristics as the



areas covered which may only be an assumption and therefore not reflective of the situation on the ground.

Research also needs to be done on factors influencing the contraceptive use among men in Kenya and focus on the socio-cultural obstacles that hinder men from practicing family planning despite the very high knowledge which they possess. Research should focus on ways of eliminating barriers to practice of family planning that are mostly persistent in these patriarchal societies. Since culture cannot be done away with, programmes should be designed to address these cultural values to accommodate family planning information without necessarily changing them.

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