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FACTORS THAT HINDER MARRIED MEN FROM PARTICIPATING IN
FAMILY PLANNING IN NAIROBI, KENYA; A CASE OF KIBERA
SLUMS. ^

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C/50/P/8776/2001

A Research Project presented in partial fulfillment of the requirements of the department of sociology for the award of the Degree of Master of Arts in Sociology with specialization in Counseling

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UNIVERSITY SUPERVISOR

This project has been carried out under my supervision and submission is hereby made to the University for Examination with my approval as the university supervisor.

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DECLARATION

I declare that this is my original work and has not been submitted in any other university.

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SIGNATURE



DATE

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DEDICATION

This project would not have been undertaken and completed without ELYON- God the most high. This work is affectionately dedicated to my loving wife and best friend Nancy; your support and prayers have been greatly instrumental in making this project a reality. This could not have been possible without your immense encouragement. To my wonderful sons Patrick and Erick; you encouraged me to balance being a daddy with studies; always keeping me on my toes to listen to you. then books. I have set a benchmark for you to break it. You may not know this but I was putting in a lot of effort to complete this research so that you don't catch up with me at the university.

A very special dedication to my late brother Charles Kimani Ngaruiva. You taught me the virtue of hard work. I wish you lived long to read this document.

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LIST OF ABBREVIATIONS

- AIDS Acquired immune deficiency virus
- CDPA Centre for Development and Population Activities
- DCH District Director of health services
- EU European Union
- FGD Focus Group Discussion Family planning
- FHI Family Health International
- HMIS Health Management Information System
- IPPF International Planned Parenthood Federation
- MOES Maternal and child health Ministry of education and sports
- MOH Ministry of Health
- PSI Population service international Reproductive Health
- USAID United States agency for international development
- WHO World Health Organization

ABSTRACT

Family planning programs have traditionally focused on women as the primary beneficiaries and men have been considered as the silent partners of the services. Research on contraceptive use and acceptance has mainly concentrated on the methods while few studies have examined the barriers affecting the individual fertility regulation decisions or the decision making dynamics within couples. Even though perspectives on male involvement are often rooted in negative assumption, family planning (FP) is not a woman affair alone as it requires a joint effort of both wife/ sexual partner to consider success of its use. When effective, it reduces unplanned pregnancies, reduces fertility rate improving hence the health of both the children women and the economic status of the family communities and the country. This was a descriptive cross-sectional study that utilized both qualitative and quantitative methods of data collection to assess the knowledge, attitudes and practices on married men who are residing in Nairobi's populous Kibera slum, aged between 15 years and 49 years on participation in family planning. The study included only married men regardless of whether they are staying with their wives or not. Laini Saba one of the nine villages in Kibera slum was purposively selected because it has relatively higher population density than the other areas and also easily accessible. The estimated population of the area is 100,000, there are no well defined divisions in Laini Saba however, for the purpose of this study, it is seen to be in four sections, namely; A, B, C and D, each with a population of approximately 25,000 (KDS 2008). Having obtained verbal informed consent from respondents, Standardized Questionnaires were administered and Interview schedule were used to capture data from the respondent, whereby the knowledge, attitude and practice on barriers to participation of men in family planning was collected. Focus group discussion and in-depth interview guide were used to complement the structured questionnaire,

The results indicated that the knowledge of family planning was high and these findings are consistent with the findings of Kenya Demographic Health survey 2006. Men are more interested in reproductive health than most people think. Recent surveys and studies seem to contradict popular views about men's participation and involvement in family planning for example, that most men know little about contraception, do not want their partners to use it, and are not interested in planning their families. This study's respondent's knowledge on family planning was quite high. The mass media was found to be the first and most common sources of family planning information. Most of the respondents wanted more information on family planning. Most of the respondents, three-quarters discuss family planning with their wives. However, men mostly make the decision on family planning. A quarter of the respondents feared

their wives practicing family planning. The fears included; infidelity and lack of respect for them. More than two-thirds of the respondents said avoiding pregnancy is the responsibility of women. However, majority of them makes decision on family planning. Almost a quarter of them does not approve of male contraception, those who approved said the condom was the most ideal for them. About one-quarter of them are not currently using a method with their wives. The reasons given include: intend to get another child, Religion, not yet decided, health reasons and wife disapproves. Slightly less than a third would like their wives to use contraceptives.

Since men's knowledge of, and expressed interest in, family planning methods is generally high in the study area it is therefore recommended that more emphasis is put on men's participation in reproductive health. Plans to intensify programme outreach and initiate male motivational campaigns possibly through print, electronic media, barazas, and dramas should be encouraged and even promotion of condom use possibly through social marketing and distribution at places appropriate and convenient for men.

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BACKGROUND AND PROBLEM STATEMENT

1.0 BACKGROUND

Family planning is a method used by couples or individuals to regulate their fertility rate to a convenient period of time when they are ready to have children. It may be a natural method or a modern type of family planning and they get children by choice and not by chance. Some of the family planning methods such as condoms are used to prevent sexually transmitted infections and are among the few methods used by men. Although there is a decline in fertility levels in the world, rapid population growth remains a critical issue in most developing countries, where needs are greater and resources are scarce. A slow population growth aids development, it buys time and with more of the demographic bonus that can be invested in education, job creation, health care, and other efforts to raise living standards. (USAID et al, 1999).

Family planning programmes have long been recognized for their importance in improving the health of women and children and in reducing population growth rate. However, Africa as a whole has lagged behind other world regions in the adoption and expansion of family planning. Given the critical role that African men play in family decisions, men's support and involvement are essential for family planning to become more widespread. If organized, family planning and reproductive health programmes are to reach out to men, a better understanding of their reproductive intentions is essential.

Men's involvement in family planning either as users of male methods or as supportive partners of users has largely been ignored by family planning program planners and service providers. Because of women's unique role in reproduction, most modern contraceptives developed over the past few decades have been for women. In addition, family planning services generally have been offered through Maternal and Child Health (MCH) care providers, bypassing men's involvement. However, exclusion of men from family planning programmes may have

contributed to the low levels of use among couples and deprives men of an opportunity to exercise reproductive responsibilities.

Rapid population growth, low agricultural production and environmental destruction have been common in Africa more especially in sub-Saharan countries. Employment is limited and poorly paying and education is expensive. Traditionally, the status and wealth of a farmer depended on the size of family. Children were a sign of success and increased an individual social standing. They were involved in herding animals, fetching water and wood, preparing food and caring for other siblings. However, many people in sub-Saharan Africa are beginning to see the benefits of smaller families. In Kenya since the 1980's the use of contraceptive have eased from 7% in 1980 to 33% in 1998 with Total Fertility Rate (T F R) reducing from 8.3 to 4.7. (Miller & Miller et al 1998)

A lot of women especially those at high risk die every year. Latest statistics show that over 500,000 women are dying yearly during pregnancy and childbirth. Most of these are those at risk, that is. too young, too old, too close or too ill to have children safely. Most of these deaths (about 90%) take place in the developing countries that includes Kenya (ICPD 2008). The 1994 International Conference on Population and Development (ICPD) and the 1995 4th World Conference on Women underscored the importance of men's roles in eliminating gender inequalities and easing women's domestic burdens. The newest generation of population policies and programmes is placing increasing emphasis on encouraging men to take an active role in all aspects of family life including family planning (GOK 2008)

The importance of involving men in reproductive health and family planning (FP) is widely discussed in the literature, especially after the proceedings of the ICPD conferences (Adewuyi and Ogunjuyigbe, 2003; Oyediran et al., 2002). Until recently, most of the large-scale family planning surveys - the Knowledge, Attitudes and Practice surveys; the World Fertility Surveys; the Contraceptive Prevalence Surveys; and the first rounds of the DHS collected RJH/FP data from only women (Drennan and Robey, 1998). The limited options of modern male methods may be the reason why these surveys have paid little attention to understanding men's knowledge, attitudes and practice of contraception (Ringheim, 1993).

When men are given knowledge on family planning and their attitude towards contraceptive use changes, then they can be good advocates to fellow men and their wives in encouraging them to use family planning, hence fertility reduction. There are more than 6 billion people in the world today and growing by 80 million people each year. Current estimates project a global population of 10 billion by 2050, in which 97% of the total population growth will take place in developing countries (World Population Data Sheet, July 2005 est.), while the United Nations projections range from 7.9 billion to the medium variant of 9.8 billion and the highest of 11.9 billion (Jodi, 1992). The other reasons for involving men in family planning mainly includes the growing HIV / AIDS pandemic, which has engulfed a large population in Africa and else where, and the need for men to use condoms. This calls for the exercise of responsible reproductive behaviour by both men and women in the prevention of further spread of the infection (Drennan and Robevl, 1998; Khan and Patel, 1997).

Moreover, men represent about half of the world's population, and use less than one-third of contraceptives, which are male methods or methods that require participation of both partners (FHI, 1998; Ringheim. 1993). The adaptation and correct use of female methods of contraception have been found to be positively affected by male involvement in family planning. Moreover, men are more interested in reproductive health information than has generally been assumed (FHI, 1998). Other compelling reasons for involving men in family planning are that millions of pregnancies are unwanted each year due to lack or failure of contraception and thousands of women die due to pregnancy complications where male involvement can a make difference (Drennan and Robey, I 998).Moreover, the international consensus reached at ICPD in Cairo created a momentum for action for male involvement in reproductive health (Khan and Patel, 1997; Roudi and Ashford, 1996).

2.0 Problem Statement

Involving men and obtaining their support and commitment to family planning is of crucial importance in the African region, given their elevated positions in the African society. Most decisions that affect family life and political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level. The involvement of men in family planning would therefore not ease the responsibility borne by women in terms of decision making for family planning matters, but would also accelerate the understanding and practice of family planning in general (IPPF 1984).

In 1975 a World Health Organization (WHO) expert committee defined five methods which can be used to evaluate the success of Family Planning Programmes. One of them was the evaluation of knowledge, attitude, and use of family planning among people as these are important determinants of the adoption of Family Planning methods by people. Little is known about men's role in the adoption of Family Planning methods in Kenya. Men have often been neglected in both Family Planning programmes and in researches used to design and evaluate such programmes.

Studies have shown that Africa has one of the highest fertility rate and HIV/AIDS infections in the world, but fosters the lowest rate of contraceptive use is in sub-Saharan Africa. The region stands out as that with the highest unmet need for contraception in the world. In Africa a woman's chance of dying from pregnancy-related causes, averages 870 per 100,000. This means, a woman's risk of dying from a single pregnancy is about 1 in every 140 live births. In East Africa antenatal mortality rate (MMR) 1,060 per 100. 000 compared to women elsewhere. Women in most sub-Saharan countries bear children at younger ages and make much less use of FP. Countries with highest rate of fertility also have the highest rate of maternal, infant and child

mortality .In Africa the average number of live births per woman is 5.6.[Family planning practice :Africa 1999]

Pregnancy-related illness and deaths are a major threat to the health and well being of women. Half of maternal deaths are attributed to abortion. (Miller & Miller 1998). Apart from this about 99% of men have the knowledge of contraception yet only few have ever used a contraceptive. Men are the decision -makers at the household level. They control resources and women would rely on them to make decisions concerning the family size, resources as in terms of transport to the health facility and many others. Men involvement may therefore increase FP uptake. To identify the barriers that deter men would provide additional information required to increase FP use. This research will also help to ascertain men's reactions, concerns and information needs that can be used in designing and formulating new or modifying existing FP strategies.

Despite the high level of awareness among Kenyan men on family planning as reflected in the KDHS), there are still aspects that hinder the utilization of family planning services. These aspects include: rumors like use of contraceptives result in infertility, side effects of contraceptives and desire for more children .The level of fertility in Kenya as in any other African country is an important factor underlying population growth rate. Since men in Kenya are the decision-makers, for example regarding the number of children a family should have, their involvement in planning is of crucial importance if any headway is to be made in modern contraceptive use

Historically, most family planning programs offer their services exclusively to women. Program planners often assume that a client who pursues family planning services meets certain criteria: she is a woman, she is married and she is in a stable monogamous relationship where she has an equal voice in family planning decision-making. This is mostly not the case. Maintaining these assumptions about client's places upon women the entire burden of preventing unwanted pregnancies, of using contraceptives or of seeking treatment for infertility or for other reproductive health concerns. The society has bestowed women to take all of these responsibilities without thinking critically about how to encourage their male partners to share these burdens more equally. Furthermore, by assuming that family planning is solely a women's issue, we have not educated men adequately about their own reproductive health needs (ndang' 2005).

Despite the availability of free family planning services, there is an imbalance on the basis of men and women in the access of these services. What factors could be responsible for the failure by the health care delivery system to ensure equality on the basis of men and women access to family planning services? Could it be that there are community, familial and/or psychological factors like men, due to cultural prescription and through family and media systems think that their roles are only to be economic providers (high value many cultures place on large family size); because men are pre-occupied with other income generating activities; many men are regarded generally as plainly "uninterested", or "unconcerned" about participating in family planning activities;

2.1 Research questions

What are the attitudes that describe men's involvement in family planning?

What is the level of men's knowledge on family planning in their households?

What socio-cultural factors hinder men from practicing Family Planning

2.2 General objective:

To determine the factors that hinder men's participation in Family planning.

2.3 Specific Objectives

1. To assess men's attitudes towards Family planning.
2. To identify the level of men's knowledge on family planning in their households?
3. To determine the level and form of men involvement in the use of Family planning
4. To identify social-cultural factors that hinder men from practicing Family Planning

1.4 JUSTIFICATION.

In most African communities, Kenya inclusive, family planning programs started long time ago although its acceptance has been at a very slow pace. It is generally believed that African men are conservative and an obstacle to acceptance of contraceptives by African women. This has contributed to the high population growth rate and its consequences, especially in the Sub-Sahara region. This research therefore seeks to document men's knowledge on modern family planning. The study sought to describe men's attitude and practices towards family planning. It also seeks to identify family planning methods used by men and their sources of information on family planning.

While some family planning programs have been interested in involving men for more than a decade, only recently has men's participation become the focus of substantial attention. One important reason has been rising global concern over the rapid spread of HIV and this has opened up the discussion of sexual behavior. Traditionally, family planning programs have viewed women as their primary clients for three reasons: it is women who become pregnant; most contraceptive methods are designed for women; and reproductive health services can be offered conveniently as part of maternal and child health services. Some family planning programs have avoided serving men in the belief that many women need privacy and autonomy in reproductive health matters.

In Africa, men are brought up to think that family planning or reproductive health are woman's issues. Fapohunda and Todaro (2004) observed that African family structure shapes spousal perceptions of fertility and men and women do not necessarily have the same views about family planning and reproduction because their interests are shaped by expectations that are determined by the social structure of their households and community. Therefore, the failure to include men

in family planning research could reduce coverage, bias findings, and undermine applicability of findings for policy and programs. Indeed, an understanding of men's perceptions on family planning could provide more insights than are possible by studying women because men have more power than women in family planning decision making, including number of children and whether or not to use family planning. As such, their views need more careful and systematic analysis especially since those views are important determinants of women's family planning attitude and behavior [Rutenberg et al 2007].

Additionally, men dominate decisions and policies in the public domain. Therefore, an understanding of their family planning perspectives could identify program interventions to promote the use of services by men - both as family planning clients and as partners to women clients - and this, in turn, would influence family planning policies. Studies about male involvement indicate that an understanding of men's perspectives on family planning could increase use of family planning services among men. For instance, Mbizvo and Basset (1996) found that when given adequate counsel, men are likely to change initial biases against family planning .

CHAPTER TWO LITERATURE REVIEW

2.0 Introduction

This chapter reviews the findings of studies that were found closely related to men's involvement in family planning. It therefore narrowed its literature to;

- Socio-demographic information of men in family planning related studies.
- The Knowledge of men on family planning, in relation to reducing fertility rate.
- The Attitudes of men towards their involvement in family planning/reproductive health.
- The Family Planning Practices, in which men get involved, and encourage their wives toward its use.

Long before the appearance of oral contraceptives, men took the lead in controlling family size, especially in the developed countries, through use of condoms and withdrawal methods. But women now have almost total priority in the field of family planning. The risk of too many-pregnancies, family planning services offered through maternal child care workers, and the networks and the women's liberation movement have been the main factors in the predominance of women in family planning. In recent years, however, organizations and expert in family planning have recognized the need to incorporate men in family planning program. There is an urgent need, on the one hand, to understand the level of knowledge and attitudes of males towards family planning and the extent to which they perceive their responsibilities in family formation and reproductive health (Khan et al, 1997).

Although the lack of male involvement in family planning has been a topic of research and discussion since the early 1980s, during the last five years, particularly after the Cairo and Beijing conferences, it has become an important issue for women advocates, researchers and international agencies which are committed to reproductive health and gender equality. The large number of articles (Aguma. 1996) and the growing number of conferences, research projects and debates on this subject bear testimony to the importance of this issue, both from the programmatic point of view and as a process for bringing about a gender balance in men's and women's reproductive rights and responsibility (UNFP A ,1995).

In the past Family Planning programmes had focused attention primarily on women because of the need to free women from excessive child-bearing, and to reduce maternal mortality rate and Infant mortality rate through the use of modern methods of family planning. Most of the Family Planning services were offered within the Maternal and Child Health centers, inclusive of researches and information campaign also focused on women alone. This has reinforced the belief that family planning is only a women's affair, and men playing a very limited role (Lalla, 1996). However, since few studies have addressed men's issue in relation to family planning, it is in this regard that the intended study reviews researches on related topic of knowledge, attitude and practice of family planning among men.

2.1 Social demographic factors

Married men differ in their levels of current contraceptive use according to their demographic and socioeconomic characteristics, including educational attainment, urban or rural residence, age, and number of children born. Such differences resemble the differences in contraceptive use among groups of women, with some exceptions. The use of contraception may be influenced by age for instance, in surveyed countries in Africa the group of young men most likely to be using contraceptives is unmarried men ages 20 to 24. In contrast, married men ages 20 to 24 have the lowest levels of contraceptive use though the peak of contraceptive use is between ages 30 and 49 among married men (Ssekamatte et al 1996).

Education can transform attitudes and lead to questioning of traditional beliefs and practices, such as those supporting high fertility (CEDPA, 1998). The more education men have, the more likely they are to use contraception. This was realized during a survey among African states

when all 46 countries, married men's contraceptive use consistently increases with their level of education with the exception of Mauritania (Abdel-tawab, et al 1998). In Sri Lanka, husband-wife communication and contraceptive use were higher among couples with higher education (DeSilva, 1985).

A place of residence may determine access to contraceptives, services and may influence attitude and use of contraception. In Rwanda, researchers found out that contraceptive use was consistently higher among married men living in urban than in rural. Though in the Dominican Republic and, Jamaica married men in rural were almost as likely as men in urban areas to use contraception (Ssekamatte et al. 1996).

2.2 Knowledge on family planning

Knowledge is power, as it has always been said. Men need to be empowered with knowledge on family planning, to transform the attitudes against contraception so as to use it or support their partners. Surveys results suggest that most men need more family planning information, education, and services. (Ezah. et al 1996; Drennan and Robev, 1998).

Men's lack of access to services such as FP clinics and counselling services has been a barrier to family-planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. Most FP clinics cater for women, so men are uncomfortable about going to these clinics. Among reasons for this focus on women instead of men is that women bear the risks and burdens of pregnancy and childbearing; most modern contraceptives are for women; and many providers have assumed that women have the greatest stake, and interest, in protecting their own reproductive health. Men reflect the spectrum of humanity, from kind and caring to abusive and dangerous. Some do prevent women from using family planning, spread STDs to their female partners, or act in other harmful ways. Reflecting these assumptions, the clinic-based service delivery design for family planning has made it difficult to include men (Edwards 1994, Wegner 1998).

However, the majority of men are concerned about the reproductive issues of their wives/partners. The testimony from a Kenyan man is a good illustration for their concern. He explains, "After having three children, my wife went on the pill for her contraception because we could no longer afford an accident with the natural methods we were using. Her blood pressure

immediately shot up. and she was advised to discontinue. She tried other methods, but they had complications too. I felt I was unfair and it was my duty, too, to take part in family planning. One morning we went together to our local family planning clinic. I will never forget how embarrassed I felt. There was not even a single man there, just queues of women and their babies. This was a woman's world and I felt totally 10st."(Wambui. 1995).

It is important therefore for health programs to abandon labeling men and learn more about their concerns and needs, especially when designing programs for different groups of men (Danforth, 1995). Given that in many settings little effort is made to educate men about reproduction and family planning, it is imperative to understand what men are learning, from whom and where they learn it. For instance an FGD study from Kenya revealed that knowledge of contraception was overwhelming among all the category of men interviewed .Family planning was defined by the participants "as a set of action that allow a family to raise the number of children they can feed, clothe, shelter, and educate or matching family size with family resources" (Fapohunda and Naomi, 1999).

According to Ezah et al, (1996), in fact men are more knowledgeable as women about contraceptive methods. Sometimes better informed than women about male methods (Hulton et al. 1996) and sometimes less informed than women about female methods. This knowledge is usually defined as men's awareness of contraceptive methods phrased in surveys as having "heard of a particular method-and does not refer to how to use a particular method or other aspects of contraceptive knowledge (Kalipeni and Zulu 1993).

In judging contraceptive knowledge, it is evident that the study also gets to know whether men have heard /know about any contraceptive methods. A study in Bangladesh on degree and determinants of men's contraceptive knowledge revealed that the spontaneous reports of top five modern methods known were ranked as; pill (93.9%), condom (79.5%), injectables (45%), female sterilization (44.8%) and male sterilization (27.4%). Roughly 3% provided a spontaneous response of having had heard of Norplant. Norplant was also the least commonly known among all modern methods (24%). The spontaneously reported knowledge of any male modern method was 82.4 % (Islam. 2000).

2.2.1 Male involvement in family planning methods.

The study carried out in Tanzania among male methods; found that condom was the most mentioned method to have been heard about (96%), 70% had heard of periodic abstinence, withdrawal (51%) and vasectomy (48%). Among female methods, pill were most often mentioned (90%), followed by female sterilization (85%), then Depo-Provera (82%). Others were calendar (67%), loop (37%), and breast feeding (32%). Less than 15% of the men could mention other female methods (Ndenzako. 2001). Conversely in more than half of the surveyed countries, including all but three sub-Saharan African countries, the male condom is the method that men most often recognize. Many married men also have heard of OCs. In only four surveyed countries; Albania, Central African Republic, Chad, and Mauritania-have less than half of married men who had heard about OCs (Bertrand. 2003).

Research efforts have been made to learn about men's general sources of family planning information, including media exposure and their social networks (Agyeman et al, 1996). Some researcher stated that the source of information can transform into knowledge, influence attitude and promote the use of family planning. In Khans' et al (1997) study they carried out, the main sources of information about family planning methods for men were reported to be friends (65%), Mass media (47%) and health workers (11 %). Among other sources, wife was mentioned by about 6% of men. According to Ndenzako (2001) other researchers they asked men to mention where they had learned about the methods. They reported to have learned of the methods from hospital/clinics (40%), radio (15%), friends (10%), schools (3%), and newspapers and the rest had no opinion.

Men express the need to share responsibility, but many do not know where to get information on family planning, services or supplies. Services have often been offered in maternal and child health (MCH) clinics. Many men see MCH clinics and their staffs as serving only women and children and feel uncomfortable seeking information or services in such setting. Men need accurate information about contraceptive methods, women's menstrual and fertility cycles, transmission and prevention of STDs, pregnancy, child health, and their own reproductive health. They also need to know where to go for services, counseling, and answers to their questions (Gallen et al, 1986).

Crowning it all, Programs to encourage men's involvement in family planning are expanding, especially through interventions to increase knowledge and interest of men, such as information,

education, and communication campaigns using mass media, and to increase access and use of FP services by men such as community-based distribution, condom sales and promotion, workplace programs, and a few male clinics and vasectomy services. Some of the field experiences have shown that well-targeted, focused male involvement programs can have an impact on both male and female behaviors related to reproductive health (Lalla, 1996).

Some other programs have developed IEC campaign aimed at increasing the awareness and knowledge of men on family planning. However, one of the crucial questions now facing these programmes is how to move beyond increasing knowledge to Changing attitudes and practices. How to address the needs of men through different service delivery strategies is an important question (Hawkins and Kirstan, 1992). Therefore various service-delivery strategies to meet those needs can be provided in a variety of ways, including primary health care facilities, special hours for men in MCH/FP clinics, male-only clinics, STDs clinics, integration of FP promotion in AIDS prevention programs, mobile units, organized groups, income generating schemes, employment-based programs, youth programs and peer counseling, male-to-male community-based distribution of condoms, social marketing, involvement of private agencies and medical practitioners (Lalla. 1996).

Messages broadcast in the mass media are a key source of family planning information for men, one of the proven ways to reach them. It can expose male audiences to messages that can influence their reproductive health knowledge, attitudes, and behavior (Piotrow et al, 1997). Family planning messages on radio and television reach more men than women, according to research findings (CEDPA, 1998). This is so because men generally have more free time, more education, more disposable income, and in many cultures more freedom of movement than women (Green et ai, 1995; Witwe, 1997).

Radio, television, video, and newspapers all may be used in strategic ways to give men important information about reproductive health. A successful campaign is based on audience analysis and research. It follows a proven model of behavior change to design the campaign, pretest messages and materials, monitor progress, and evaluate results (Piotrow et ai, 1997). In Uganda, for example, the Busoga Diocese's Family Life Education Program reached men with information about reproductive health through short radio dramas that addressed questions such as, "How does an STD look like?"(A VSC International 1997).

However a variety of mass media may be more influential than limited ones as a study carried out in Zimbabwe used male-motivation campaign with a wide variety of media to reach more men and to expose them to multiple, reinforcing sources of information such as: radio, television, posters, newspapers, motivational talks, family festivals, a football tournament with giant puppet shows at half-time, live dramas, and musical shows. This campaign also focused on improving the quality of services by developing a new training curriculum and a video on counseling and interpersonal communication, and trained clinic-based health workers and community-based distribution agents (Lalla, 1996).

Ghana used the same strategy and it showed fruitful results. Its Health Education Division and Ministry of Health (MOH/HED) began a systematic family-planning IEC project in 1987 in which it used a wide variety of IEC materials, media, and activities. Findings indicated a significant increase in men's family planning knowledge and practice, and improvement in attitude with the increasing length of the project (Kim, et al.

However according to a study done among the African countries, 30 of the 31 countries from which data was collected, more than half of men consider family planning messages acceptable in the mass media. In the Dominican Republic, Gabon, Kenya, Malawi, Morocco, Peru, Uganda, and Zimbabwe, over 90% find family planning messages acceptable with the exception of Chad (CEDPA, 1998).

2.3 Attitudes towards Family Planning

Lack of access to accurate information about male contraceptive methods, misperceptions and fears may expose men to unwillingness to use these methods. This is comparable to a study done in Tanzania which associated vasectomy with castration or believed that it leads to impotence as noted from the FGD group discussion in which one participant said, "To have vasectomy is equated to castration of an animal", while others allege "condoms were implanted with micro-organisms" (Ndenzako, 2001).

Similarly, the unwillingness to use condoms is also based on the belief that condoms reduce sexual satisfaction or cause allergic reactions (Muhondwa and Rutemberg, 1996; Khalifa, 1988). Providers may have misconception or biases about male or men's methods in family planning as the result; they may not present information about male methods or assume that men are not

interested (Rogow and Horowitz, 1995). There are far fewer figures on men's perceptions of other aspects of contraceptive use, such as health side effects, efficacy, ease of use, privacy, and so on. One study in the Philippines focused in more details on the perceived strong views of the level of disagreement among matched spouses which was significant (Biddlecom et al, 1997). In a study carried out in West Africa nearly % of men reported that they had never discussed family planning with their wives: in East Africa less than 40% of men said they had never discussed it; and in North Africa the percentage was even lower (Ezah et al, 1996)

Nevertheless a study of lower-income Egyptian men's opinions on contraceptives found that they had specific concerns about the health and sexual side effects of contraceptives for their wives (Ali, 1996). For example in Peru young couples kept a hold on the use of contraception especially the pill. An In-depth interview revealed, that men thought modern methods would cause harm to their spouses and themselves. These men also expressed concern that the pill might increase women's sexual drive to a point that was threatening to men. These false ideas came from peers and friends (Bertrand, 2003).

Men's views of contraception may vary with the reasons for using contraceptives. For example, a study in Dakar, Senegal, found that acceptance of contraception among men was significant, even among men from the most conservative backgrounds, when it was for the purpose of spacing births (Posner and Mbodji, 1989). In order for a husband and wife to agree on the use of family planning, couples not only must discuss the topic but also accurately perceive each other's attitudes (Becker and Robinson, 1998).

Experts agree that the more the husbands and wives discuss family planning with each other, the higher the level of contraceptive use. Communication between spouses and among family/household members regarding family planning and contraceptives use is considered crucial to the adoption of contraception (Chai, 1997), and is also positively correlated with fertility behaviour. It can encourage family planning use, promote reproduction health decisions and can lead to healthier practices (Drennan and Robey, 1998; Chai, 1997). For example, in Nigeria, among men who said that they had discussed contraception with their partners, 22-60% reported that their wives used the contraceptive method, compared to 4-10% of those who said they had not discussed family planning with their wives (Oni et al, 1991).

2.3.1 The Father and Family Planning

It is suggested that issues of spousal communication across societies and its variations might be understood in terms of the different structural and cultural factors within which the couples live, that is. religious ideologies and cultural norms concerning gender roles and status which impinge upon women's autonomy. Levels of spousal communication on contraceptive use are also governed by family structure, wife's education, the perceived status of women in the family and in the community, and women's role in decision making (Chai, 1997). More outstandingly, decision-making (unilateral or joint) contraceptive uses vary much and it depends upon the gender and power relations chiefly in the family (Bhassom, 1991).

In developing countries, the husband's attitudes, preference, intentions and decisions are more important as they exert the greatest influence in couple communication and fertility decision-making (Drennan and Robey, 1998; Chai, 1997). When reproductive health decisions are made jointly by both partners, the decisions are more likely to be implemented. In Ghana, the wife's attitudes towards contraception are strongly influenced by husband's attitude and background characteristics like education, but the wife does not similarly influence the husband's views, [t is perceived that men have more influence on reproductive decisions, because they typically control the families' assets and are accepted as head of households (Ezah et al 1996). This coincides with a study in India in which approximately 2/3 of the males (65%) believed that discussions on these issues should always be initiated by men/husbands, and 28% to 34% felt that they would be offended and would react adversely if their wives took the initiative to discuss either reproductive goals or contraceptive use (Khan et al, 1997).

However where there is lack of communication it makes many women not to know their husbands think about FP if also leads to a failure to act on their commonly held preferences (Ezah et al, 1996). Traditionally, discussion between spouses' issues pertaining to sexual intercourse, contraception, or sexual play is a taboo so communication can be nonverbal. This is illustrated by one study in India which found out that Y4 of the men believed that reproduction is a natural process and does not need to be discussed. An equal proportion felt that discussions on reproduction are meaningless and do not help in any way (Khan et al, 1997).

Many women think that their husbands disapprove of FP. when in fact the husband approves. Communication may bring differences of opinion into the open, reinforcing the differences rather than reconciling them (van de Walle et al. 1991). In Uganda it is not surprising with the apparent gender ideologies obtaining in the country. Most couples prefer having sons even if it means engaging in extra-marital relations (Ssekamatte et al. 1996, UDHS, 1988-1989). Likewise in another study. Son preference too was indicated by both men and women, but this was slightly stronger among the men than their wives thus, about 4/5 of the men as compared to about 1/3 of the women felt that, they would be satisfied with only one son. The overall study showed that the desired family size is still large (three or more children), and the concept of a two child family has not been accepted by the majority of the couples (Khan et al, 1997).

2.4 Practice/ Use of Family Planning

The issue of male responsibility underlies the emphasis in population policy and programs on encouraging men to be supportive and involved partners (Green et al, 1995; Hawkins and Kirstan. 1992; United Nations 1999). In Pakistan, a study on men involvement and use of family planning methods stated that, it was important to take such a study because of their dominant role in family decision-making in the socio-structure of that region. One of the objectives was to estimate the extent to which family planning affects men's contraceptive use. The findings indicated that men's knowledge and contraceptive use had increased three times within a time period of twenty years . The important factors that determine men's contraceptive use behaviour are the approval of family planning, the communication with wife on family planning matters, and the desire for children. In addition, wife's autonomy is also important in explaining men's involvement in the use of family planning. The study also reveals that most Pakistani men approve of family planning and suggests that men should receive an equal focus together with women in the population welfare programme activities (Ali, 1996).

One of the simplest indicators that men assume responsibility for fertility control is contraception use. especially of methods that directly require men's participation. Contraceptives use varies from person to person, from natural to artificial and from temporary to permanent. According to Greene and Biddlecom (1997) study, 6% of the contraceptive users used periodic abstinence accounting for 9%. Among -the condom users 80% were unmarried while 20% were married men. A larger proportion of unmarried men (41%) were using contraception than married (14%).

Among female methods as reported by men, the Depo-Provera, calendar and pills methods were the most used (6%) each. While in another study, condoms were the most popular (54%), temporary method practiced by the subjects followed by abstinence (28%). None of the couples used Oral Contraceptive Pills or Intra-Uterine Contraceptive Devices. All couples who completed their family planning practiced Tubectomy as the permanent method of sterilization. Vasectomy was not being practiced by any of the husbands after completing their family (Rajesh et al, 2003)

Married men not only report using contraceptive methods as much as married women do, but they almost always report higher rates of contraceptive use than do married women (Ezeh et al, 1996). This may reflect true differences in contraceptive use between men and women—men may be more likely to have more sexual partners than women, it may reflect different inclinations to report truthfully or simply different interpretations of the couple's reproductive behavior. One study found that spousal differences in contraceptive use in five countries were much less likely among couples who were monogamously married or where the wife had a secondary education; and, surprisingly, men's reports of extramarital sexual relations had no effect on differential use (Ezeh and Mboup, 1997).

2.4.1 Women's role in contraception

In another study of spousal disagreement and contraceptive use, only 1/3 of couples concurred in their reported use of contraceptives: the lowest agreement was for those using condoms, abstinence, and rhythm, which men typically reported using while their wives did not (Koenig et al, 1984). Explanations for this discrepancy focused on marriage duration and interview context, spousal fertility preferences, spousal interaction, and family planning approval (Greene and Biddlecom, 1997).

Many men are directly assuming responsibility for preventing pregnancy through coital dependent methods such as condoms, withdrawal, and periodic abstinence. Studies of men's acceptance of vasectomy and condoms are relatively plentiful, especially in light of the public health problem of sexually transmitted diseases (Ringheim, 1993). One study in Thailand showed that while men may think that condom use is good in general, their views of using condoms in sexual relations with spouses may be negative because of the association between

condoms and promiscuity, disease, and commercial sex (ICnodel and Pramualratana 1995). Studies in Uganda and Tanzania also found little support among men for condom use within marriage (Ssekamatte et ai. 1996).

Despite long histories and widespread use of traditional methods, less attention has been devoted to understanding men's use of such methods as withdrawal, periodic abstinence, and postpartum abstinence. In a number of sub-Saharan African countries, more than 50% of current use is of traditional methods, periodic abstinence being predominant (Ezah et ai, 1996). Withdrawal accounts for 9% of overall contraceptive use in developing countries and is quite widely used in some countries, whereby 26% of all married women of reproductive age in Turkey reported withdrawal as their current method. Given that withdrawal is free and involves no effort to obtain, it may plava role in the sexual activity of couples who want to control their birth (Rogow and Horowitz, 1995).

Men may have different reasons for not using contraceptives as identified by different studies (Greene and Biddlecom, 1997). Desiring more children was the most frequent reason given by men as to why they were not using contraception as found in Ghana, niger and Tanzania (Ezah, et al 1996, TDHS. 1996). The transition for a small family in sub Saharan Africa is much slower (Berer. 1996). Many factors-cultural economic, political and demographic help explain the difference. The preference for large families, to large rural populations relying on subsistence farming are strong attachments (Binvange, et al 1993).For instance in parts of the Near East and - onh Africa and parts of South Asia, however, preference for male children puts up'ard pressure on fertility levels. Because many couples continue to have children until a son is bom, fertility is higher than would be the case without gender preference (Anderson and Baird, 1998).

While husbands and male partners have a tremendous impact on women's contraceptive use or non-use, other family members can play significant roles as well. In some countries, parents and in-laws view grandchildren as necessary to extend the family line, to provide labor on family farms, or to provide financial support for parents during old age. They may discourage couples from using family planning to delay pregnancy, but encourage couples to use family planning to limit or space births after they have a large family. (Wekwete. 1998)

The above findings coincide with an in-depth interview in which one participant said, "You get pressure from both your family and your husband's family to get pregnant" soon after marriage, explains Mhloyi of the University of Zimbabwe. "If you do not get pregnant in three months, people will come and say, "There is darkness in this house, having children gives women more status", she concluded. One mother-in-law told the researchers in the FGD that they encouraged contraceptive use, but only as a means of limiting pregnancies once a couple had the number of children they wanted (FHI, 2005).

Research in Zimbabwe showed that although contraceptive use is high nationwide about 48% among married women of reproductive age. contraceptive use before first pregnancy is low. Only 8% of women use family planning at the time they marry, but after first birth, the percentage increases to 59% (Mhloyi, 1998). This explains why among seven of the 15 countries surveyed in Africa, of the 90% men who approve the use of contraception, majority (56%) felt that it should be adopted only after having two children (Drennan et al, 1998). Since a woman cannot adopt any contraceptive method without her husband's permission, such a conditional approval of contraception by male could be a serious bottleneck, in the acceptance of contraceptives at low parity and its use for spacing births purposes (Khan et al, 1997)

2.5 SOCIOCULTURAL FACTORS AFFECTING FERTILITY IN SUB-SAHARAN AFRICA

The demographic transition from high fertility to low fertility is slowest in sub-Saharan Africa in which fertility declined by 1 only from 6.5 to 5.5 children per woman (UNFPA, 1999). Although some countries in the sub-region have recorded declines in fertility levels in the last three decades, certain household, kinship and community institutions that favor childbearing remain highly influential in many countries especially in western and central Africa. Contraceptive prevalence rates use, particularly of modern methods, plays a significant role in the transition from high to low fertility levels (Bongaarts, Frank and Lesthaege, 1984; Westoff, 1990; Ross and Frakenberg, 1993).

The economic theory of fertility used in demography, assumes that husbands and wives, acting as a unit, weigh the costs and benefits of children against the cost of other competing goods and subsequently arrive at desired family size that reflect their interest (Becker, 1960). This conjugal

household with its pooled resources and shared responsibilities is the one that is viewed as the primary locus of reproductive decision-making. If this were so, then it should be easy to offer couples sufficient incentives to make them prefer smaller family size. In most African households, however, couples are more likely to have different interests as regards fertility and other issues. Decision-making about children is more likely to be predicated on family status and considerations for the preservation of lineage and respect for ancestors. According to traditional beliefs, ancestors are reincarnated through additional births (Makinwa-Adebusoye and Ebigbola, 1992; National Research Council. 1993).

Because the Economic Theory of Fertility with assumptions based on urban. Western industrialised countries does not conform to African reality, Caldwell (1977) has put forth the "wealth-flows theory". Caldwell argues that the inter-generational transfer of wealth, which he assumes, is usually from children to parents, is a major determinant of high fertility. This theory addresses the rural nature of most African households and transfer of wealth which he assumes are predominantly subsistence agricultural (rural) economies such as prevail in most sub-Saharan African countries, large families constitute family assets. However, some studies have shown that wealth flow have little effect on childbearing. In fact, increasing costs of children to their parents are beginning to outweigh material benefits to an extent that may be influencing reduced desired fertility (Makinwa-Adebusoye, 1994). Noting other aspects of the African household, Fapohunda and Todaro (1988) have suggested the "Transactions Framework" which places the locus of reproductive decision-making at the individual rather than at the household level.

Polygamy, lineage and kinship networks

The effect of polygamy on fertility is complex. By definition, each polygamous household has at least two wives. The relevant consequence of polygamy is that women marry at a very early age. Since men take several wives, they put pressure on the supply of girls (since the numbers of males and females are about the same). In addition, the pressure to have more than one wife leads older men to recruit young girls into marriage thereby increasing the likelihood of women marrying polygymously to be withdrawn from school and to marry at an early age.

Another characteristic of the African household that has direct bearing on demand for children is its durability or perpetuity. It is generally accepted that lineage does not die; members die and

are replaced through births. Consequently, there is need to ensure that fertility levels remain higher than mortality levels if the lineage is not ultimately to disappear. Considerable expansion of membership enhances the power and prestige of the lineage and reduces the likelihood of extinction through death. In addition, enormous weight is maintained to family continuity because each new birth in the lineage is regarded as providing a vehicle for the return of an ancestor. Hence, to prevent a birth is viewed as tantamount to consigning an ancestor to oblivion (Bleek, 1987; Makinwa-Adebusoye and Ebigbola, 1992; National Research Council, 1993; Caldwell and Caldwell 1987). Desire to perpetuate the lineage results in large kinship networks.

the extent to which women enjoy any decision-making is powerfully shaped by social institutions (Mason, 1984). The patriarchal, hierarchical and polygynous organization of many African households tends to perpetuate the low status of women in African societies. In such households, most women cannot exert much, if any, control over their lives in the families within which they live. Early marriage, residence after marriage and polygynous unions are institutions that perpetuate women's subordinate position and make them rather voiceless and powerless in matters affecting their reproduction. At marriage a woman assumes a low status relative to all members of her husband's extended family which is elevated usually by attainment of high fertility, and can be elevated by high educational attainment and ownership and control of substantial resources (Makinwa-Adebusoye, 1992).

.Africa is primarily rural and its highly gender-stratified cultures are very supportive of high fertility. Indeed, pronatalist institutions notably patrilineal descent, patrilocal residence, inheritance and succession practices, and hierarchical relations have remained unchanged for generations. This situation has given rise to the widely canvassed viewpoint in literature on Africa (Caldwell and Caldwell. 1990, Caldwell and Caldwell, 1987, Frank and Mc Nicoll. 1987) that the pronatalist institutions are so deeply entrenched that they are immutable and likely to remain unresponsive to modern innovations. Implicit in this perspective is that because of these entrenched props of high fertility, African countries might not join in the fertility decline already noticeable in other Less Developed Regions. However, data from recent fertility and health surveys do not support this viewpoint.

2.5 THEORETICAL FRAMEWORK

2.5.1 Social cognitive theory

Social cognitive theory provides a framework for understanding, predicting, and changing human behavior. The theory identifies human behavior as an interaction of personal factors, behavior, and the environment (Bandura 1977; Bandura 1986). In the model, the interaction between the person and behavior involves the influences of a person's thoughts and actions. The interaction between the person and the environment involves human beliefs and cognitive competencies that are developed and modified by social influences and structures within the environment. The third interaction, between the environment and behavior, involves a person's behavior determining the aspects of their environment and in turn their behavior is modified by that environment.

In conclusion, social cognitive theory is helpful for understanding and predicting both individual and group behavior and identifying methods in which behavior can be modified or changed. The Social Cognitive Theory is relevant to health communication. First, the theory deals with cognitive, emotional aspects and aspects of behavior for understanding behavioral change. Second, the concepts of the SCT provide ways for new behavioral research in health education. Finally, ideas for other theoretical areas such as psychology are welcome to provide new insights and understanding. The three factors environment, people and behavior are constantly influencing each other. Behavior is not simply the result of the environment and the person, just as the environment is not simply the result of the person and behavior (Glanz et al, 2002). The environment provides models for behavior. *Observational learning* occurs when a person watches the actions of another person and the reinforcements that the person receives (Bandura. 1997). The concept of behavior can be viewed in many ways. *Behavioral capability* means that if a person is to perform a behavior he must know what the behavior is and have the skills to perform it.

Social Cognitive Theory (SCT) views learning in terms of the interrelationship between behavior, environmental factors and personal factors. It also provides the theoretical framework of interactive learning used to develop both Constructivism and Cooperative Learning. According to SCT, the learner acquires knowledge as his own environment converges with personal characteristics and personal experience. New experience are evaluated vis-a-vis the

past; prior experiences help to subsequently guide and inform how the present should be investigated. The Social Cognitive Theory is relevant to health communication. First, the theory deals with cognitive, emotional aspects and aspects of behavior for understanding behavioral change. Second, the concepts of the SCT provide ways for new behavioral research in health education. Finally, ideas for other theoretical areas such as psychology are welcome to provide new insights and understanding.

The social cognitive theory explains how people acquire and maintain certain behavioral patterns, while also providing the basis for intervention strategies (Bandura, 1997). Evaluating behavioral change depends on the factors environment, people and behavior. SCT provides a framework for designing, implementing and evaluating programs. **Environment** refers to the factors that can affect a person's behavior. There are social and physical environments. Social environment include family members, friends and colleagues. Physical environment is the size of a room, the ambient temperature or the availability of certain foods. Environment and **situation** provide the framework for understanding behavior (Parraga, 1990). The situation refers to the cognitive or mental representations of the environment that may affect a person's behavior. The situation is a person's perception of the place, time, physical features and activity (Glanz et al, 2002). For example , SCT could be used to encourage men to get involved in family planning interventions in so far as a fairly conservative male maybe more willing to learn or emulate a renown or respectable public figure who may share experience s that resonate with the mans unique personal history. Ideally the man's affinity with the celebrity will help him comply for good.

2.5.2 Health Belief Model

The Health Belief Model (HBM) is one of the most widely used conceptual frameworks for understanding health behavior. It is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. Developed in the early 1950s by social psychologists Hochbaum, Rosenstock and Kegels the model has been used with great success for almost half a century to explore a variety of long and short term health behaviors, including but not limited to health seeking behavior. The key variables of the HBM are as follows (Rosenstock, Strecher and Becker. 1994):

Perceived Threat: Consists of two parts: perceived susceptibility and perceived severity of a health condition.

Perceived Susceptibility: One's subjective perception of the risk of contracting a health condition.

Perceived Severity: Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).

Perceived Benefits: The believed effectiveness of strategies designed to reduce the threat of illness.

Perceived Barriers: The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.

Cues to Action: Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action. A cue to actions is an aspect of the HBM that has not been systematically studied.

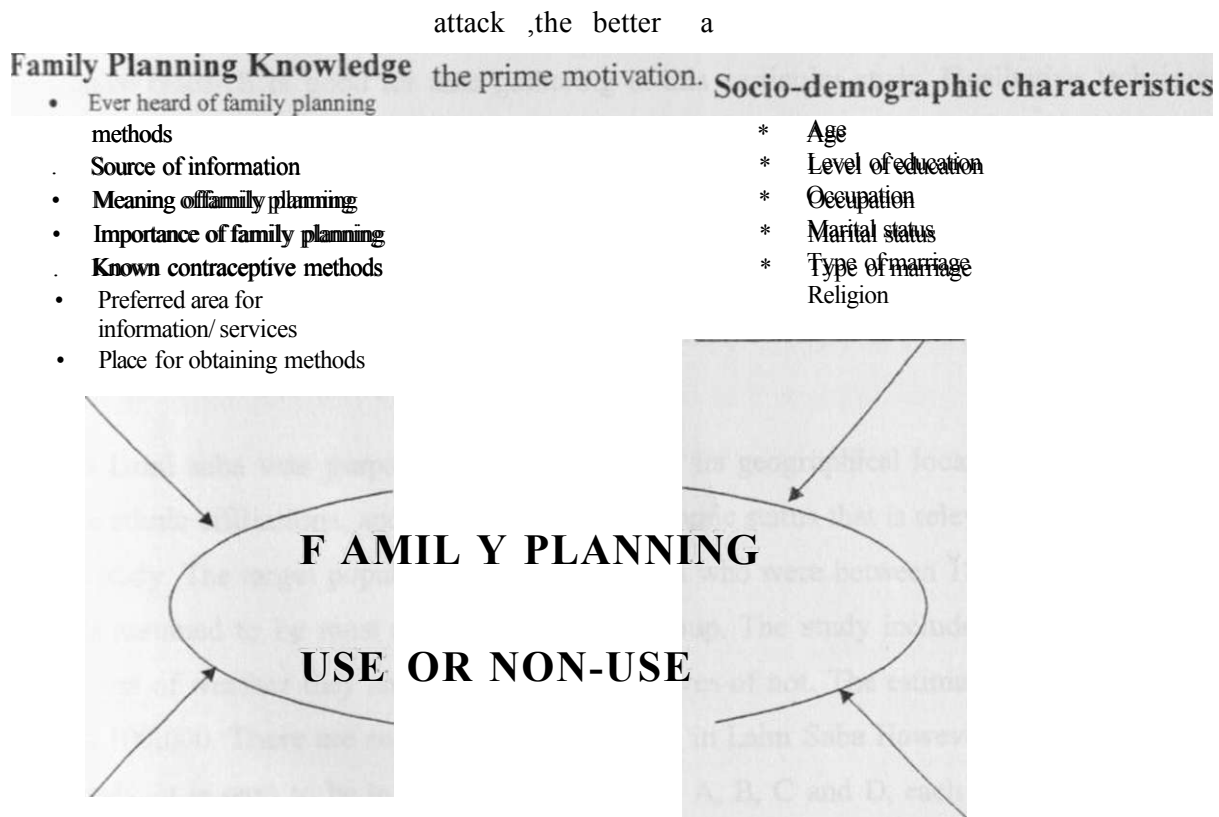
The health belief model is a framework for motivating people to take positive health actions that uses the desire to avoid a negative health consequence as the prime motivation. For example, an excess number of children could be assumed to be a negative health consequence for the men not involved in family planning, and the desire to avoid the this outcome can be used to motivate the men. It is important to note that avoiding a negative health consequence is the key element of the HBM. A person for example may increase exercise to look and feel. That example does not fit

the model because the person is not motivated by the negative health outcome- even though the health action of getting mote exercise is the same as for the person who wants to avoid a heat

2.5: Conceptual Frame Work

This area has reviewed factors perceived and real that influence the knowledge, attitude, and practice of family planning among men. Both independent and dependent variables were used in this study. The independent variables included use and non-use of family planning among men. The dependent variables were knowledge, attitude and practice on family planning which are linked to the independent variable because of its influence on them as seen in the conceptual frame work below.

Conceptual frame work



Family planning Attitude

- Rumor associated with the use of family planning
- Fear for FP Use
- Belief for initiator ofFP discussions
- Desired number of children
- Preferred sex

Family planning practice

- Ever use
- With whom
- Reasons for use
- Method(s) ever used
- Current use
- Determinant for use
- Number of children

CHAPTER THREE: METHODOLOGY

3.1 Introduction

Kerlinger (1964:275) defines research design as a plan, structure and strategy of investigation conceived so as to obtain answers to research questions and variances. A research design guides the researcher in collecting or gathering, analyzing and interpreting observed facts. The methodology comprised of review of literature, a general and specific description of the study area, definition of the study population; sampling plan: design and method; developing and using standardized instruments that include key informant interviews, focus group discussions, semi-structured interviews; and data analysis. This section gave an elaborate outline of the research and data collection plan. The study sought to address the following areas in this section: scope of the study, sources of data, data collection techniques tools and analysis

Qualitative research is good for data gathering in this particular study. Qualitative techniques enable the researcher to gain emphatic understanding of social phenomena; facilitates recognition of objective aspects of human behavior and experiences, and to develop insights into group's lifestyles and experiences that are meaningful, reasonable and normal to those concerned (Njeru 2004)

3.2 Site Selection and description

Kibera Laini saba was purposively selected due to its geographical location, accessibility its diverse ethnic affiliations, and the target socio-economic status that is relevant to the objectives of the study. The target population was married men who were between 18 years and 49 years. This is assumed to be most active reproductive group. The study included only married men regardless of whether they are staying with their wives or not. The estimated population of the area is 100,000. There are no well defined divisions in Laini Saba However, for the purpose of this study, it is seen to be in four sections, namely; A, B, C and D, each with a population of approximately 25,000 (KDS 2008)

3.3 Research design

According to Singleton et al, (1988:67) "research design is the arrangement of the conditions for the **collection** and analysis of data in a manner that aims to combine relevance to research **purpose** with the economy in procedure*'. Survey method constituted the major research design for **this** study. (Mahiltra (1996) describes the survey as a method where a structured **questionnaire** is given to a sample population designed to elicit specific information. According to Peil (1995), the survey method if well used, can provide reliable, valid and theoretically meaningful information. It does this by asking a number of people the same questions making it **possible** to get an accurate picture of the characteristics of the elements under the study.

This was a descriptive cross- sectional study that utilized both qualitative and quantitative methods of data collection to assess the knowledge, attitudes and practices on men's participation in family planning.

3.4 Unit of analysis

The unit of analysis is that which the study attempts understand and explain. According to singleton et al 1988:69 a unit of analysis is the entity under study which could include people, social roles, positions and relationships. Schult [1996:88] defines a unit of analysis of a study as the level of social life on which research question focus. It could be individual people, groups, towns or nations. The unit of analysis for this study was factors that hinder men's participation in family planning.

3.5 unit of observation

This is defined as the subject, object, item, parameter, or entity from which the characteristics are measured or data required in the research study are obtained. For purposes of this study, the units of observation were the married men of Kibera Laini Saba.

3.6 Sampling procedure

Laini Saba one of the nine villages was purposively selected. Reasons were, it has relatively higher population density than the other areas and also easily accessible. Respondents were drawn from all the four clusters. Households were my main sampling units. From the central point of each cluster, a pen was randomly thrown and the pointer used to indicate the starting

point of the interview. All households in that line were visited until the end of the line. Then from the centre of the cluster, a pen was thrown to give the next direction. This was repeated until the intended number of households was visited.

3.7 Sample size determination

The sample size was determined using a standard formula

$N - m$

d^2

Where;

Sample size from a population > 10,000

Z= Standard normal deviate set at 1.96 at 95% confidence level.

p= Characteristic about the target population is not known, so (50% or 0.5), which is the standard for unknown populations have been used.

d=Absolute precision of size at 5% Level of Significance I.e. 0.05,

Therefore, $\frac{1.96^2(0.5)(0.5)}{(0.05)^2}$

sample size = 120 men.

(Fisher 1991, Schlesselman, 1974).

Types and tools of data collection

Primary data

To assemble this, the following methods was used

Structured interviews

A structured *questionnaire* comprising of about 30 questions were used as the instrument of data collection. This was used to carry out a survey of 120 questionnaires. The questionnaires were specifically designed for the study as no relevant, validated questionnaire was found to suitable. However, a number of the questions included within the booklet are similar to those used in a previously published research studies.

Key informant interviews. Interview schedules were be used to gain more insight to supplement the structured interviews. The researcher assured each interviewee that responses will be treated confidentially and that the answers they give, will not by themselves, be responsible for the findings of the team.

Secondary data

This was used to supplement primary data. To assemble these research reports, journal and website materials were reviewed to give the required data.

Data collection, analysis and presentation

Data collection

Having obtained verbal informed consent from respondents. Standardized Questionnaires were administered. Interview schedule were used to capture data from the respondent, whereby the knowledge, attitude and practice on barriers to participation of men in family planning was collected. Focus group discussion and in-depth interview guide were used to complement the structured questionnaire.

Data analysis

All quantitative data collected was coded and entered into computer software the SPSS version 12.0 data was cleaned by running frequencies and all errors of data entry were corrected by referring back to the questionnaires. Descriptive statistics was carried out for all categorical and continuous variables. Descriptive analysis was done using proportions and frequency distributions for categorical variables and measures of central tendency (mean, median and mode) for continuous variables. Chi-square test used to test associations among categorical variables. Presentation of quantitative data done using tables, text and figures. Qualitative data was analyzed thematically.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.0 INTRODUCTION

This chapter covers the findings of the study. In this chapter, the primary data for the study is analyzed in detail. Secondary data has been applied to the subsequent analysis. This chapter presents both qualitative and quantitative findings. This chapter has been organized in sections covering social demographic information of the study population, the knowledge level, attitudes and practices pertaining to modern family planning method among married men in Kibera slum Nairobi. The findings are presented in text, tables and figures.

4.1 Socio-demographic Characteristics

Table no.1 socio-demographic characteristics of respondents

CHARACTERISTIC	FREQUENCIES	PERCENTAGE
AGE		
20-24	16	13
25-29	30	25
30-34	27	23
35-39	23	19
40-44	16	13
45-49	18	15
Years of marriage		
Less than 2 years	18	15
2-5 years	43	36
6-10 years	28	23
More than 10 years	31	26
No. of children		
IL-2	60	50
I-34	33	27.5
	20	16.7
J and above	7	5.8
Education level		
None	11	9
Primary	47	36
Secondary	50	45
Tertiary	12	10
Occupation		
Employed	50	41.7

Casual laborer	30	25
Self employed	40	33.3
Religion		
Christian	105	82
Muslim	15	18

Majority of the respondents 28 was between 25-29 years old. The minimum age was 20years and the maximum 49 years. Majority of the respondents 117(97.5%) were married while 3(2.5%) were widowed. The study revealed that (37%). more than a third got married between six and ten years ago. It was established that (24%) got married two to three years ago. Majority of the respondents 107(89.2%) had one wife each and only 13(10.8%), had two wives each. Slightly more than half of the respondents 68(56.7%) had their wives staying with them, most of the time, while the rest did not. The study revealed that 60 (50%). exactly half of the respondents had one to two children followed by 33 (34.5%), slightly more than a quarter had three to four children The study revealed that 60 (50%), exactly half of the respondents had one to two children followed by 33 (34.5%). slightly more than a quarter had three to four children Slightly less than half 56 (47%) have had secondary education followed by 46 (38% more than a third with primary level education. Every four out of ten 50 (41.7%) of the respondents reported that they were employed, while one-third 40 (33.3%) were self-employed during the time of the survey Majority of the respondents 105 (87.5%) subscribed to the Christian religion with almost two-thirds belonging to the denomination protestant. 77 (64.2%) and a fifth 28 (23.3%) Catholic the rest were Muslims.

4.2 KNOWLEDGE

4.2.1 Knowledge on family planning

Table 2: Knowledge on family planning

Response	Frequency	Percentage
Don't know	6	5
Few children	36	30
Children spacing	54	45
Ability to support children	24	20
Total	120	100

Slightly less than half of the respondents 56 (46.6%) gave the definition of family planning as "giving birth to the number of children one can support," While only a fifth 24 (20%) said "it was spacing of children" However 2 (1.7%), could not give any definition. This shows a fairly good knowledge of the respondents on family planning Knowledge on family planning in the area seems to be quite high as confirmed by both sexes through information obtained from separate focus group discussion, in the study

4.2.3 Benefits of family planning

Table 3 Benefits of family planning

Response	Frequency	Percentage
Don't know-	4	3.3
Better health	29	24.2
More time with children	4	3.3
Ability to provide	70	58.2
Total	120	100

It is impressive to note that majority of the respondents 70 (58.2%). gave the benefit as being able to provide for the needs of their children. However 3.3% did not know any benefits. Benefits given through focus group discussion include:" less burden", "it brings love to the family." and that "it enables the government to plan better services for the nation". One of them said "cost of living is now very high, why don't we have few children that we can conveniently take care of. This shows a good knowledge on the benefits of family planning.

4.2.4 Main source of family planning information

Table 4: The main source of family planning information

Source	Frequency	Percentage
Media	48	40
Colleagues	36	30
Posters magazines	6	5
Neighbors	18	15
' Health workers	12	10
Total	120	100

The study revealed that 48 (40%) of the respondents get most of their information on family planning from the radio, followed by colleagues 36(30%)

43 ATTITUDE

4.3.1 Whether respondents had discussed family planning with their wives?

Three-quarters of the respondents 90(75%), reported to have had discussions with their wives on family planning. Out of this number 55(61.1 %) started the discussion themselves, while 35(38.9%) had the discussion started by their wives. Slightly more than half 57(50.4%) make decisions alone on family planning, while the rest 47(41.6%) make decision on family planning with their wives.

4J.2 Responses on their wives practicing contraception

Table 5: wives practicing contraception

Source of fear	Frequency n=30	Percentage
Infidelity-	22	73.4
Lack of respect	7	23.3
Fear of AIDS	1	3.3
Total	30	100

4.33 Number of children considered as an ideal family size.

Majority of the respondents 64(53.3%) consider 3-4 children as their ideal family size followed by 24((20%) 1-2children, 17(14.2%) as many children as per income, 15(12.5%) 5-6 children.

4.34 Responsibility for avoiding pregnancy

Half of the respondents 60(50%) said both men and women are responsible for avoiding pregnancy while 51 (42.5%) said only women are responsible Only 9(7.5%) said men are responsible.

4.35 Approval of male contraception.

It is quite impressive to note that over three-quarters 91 (77.1 %) approve of male contraception. Out of this number over four-fifths 80(87.9%) approve of the condom while only 11 (12.1 %) approve vasectomy as a method that males should use. It is surprising to note that more than half 70(58.3%), have never used any form of male contraception. More than four-fifths 43 (87.8%.) of those who have ever used a male contraception mentioned condom as their method. The rest 6 (12.2%) mentioned vasectomy. About two-thirds 77(65.3%) of the respondents reported to be currently using a family planning method.

4.3.6 METHODS USED BY RESPONDENTS /WIVES

Table 6: METHODS USED BY RESPONDENTS /WIVES

Method	Frequency n=78	Percentage
Pill	29	37
Natural method	21	26
Injectable	4	5
Condom	6	8
Intrauterine device	8	10
Tubal ligations	4	5
Vasectomy	1	1
Norplant	5	6
Total	78	100

5.4.4 Reason for not using family planning

Table 7: Reason for not using family planning

Reason	Frequency n=41	Percent
Intends to have another child	12	30
Religion	12	29
Health concerns	8	19
^ ife disapproves	9	22

Table 8 methods respondents would like their wives to use n=97

Method	Frequency	Percentage
Pill	23	24
Natural method	25	26
Injection method	30	31
Condom	1	1
Intrauterine device	4	4
Tubal ligations	8	8
Norplant	1	1
Total	97	100

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 DISCUSSION

Discussion on the findings is presented in relation to knowledge, attitudes and practices, of married men on modern family planning. The discussion is based on findings of data collected in the field during the investigation. Majority of the respondents in the study were young men. The minimum age was 20 years, the mean and median ages were 30 years and 32 years respectively. This implies that most of them were in their very active ages and will therefore have more children with their spouses if no contraceptive intervention is taken. Nearly half of them had secondary education and very few were illiterate. This suggests a high level of literacy. It would be expected that literacy would lead to awareness in terms of modern family planning methods with their spouses. However, a significant portion of the respondents were Christians and a reasonable number of them were Roman Catholics. Since the Catholic Church prohibits its members from practicing modern family planning, this may explain why some of the respondents do not approve family planning.

Knowledge of family planning was high and these findings are consistent with the findings of Kenya Demographic Health survey 2006. Men are more interested in reproductive health than most people think. Recent surveys and studies seem to contradict popular views about men's participation and involvement in family planning for example, that most men know little about contraception, do not want their partners to use it, and are not interested in planning their families.

Reasons mentioned in the survey for not using condoms included availability of alternative methods, messiness of condoms, unreliability, and desire for more children. Men in Laini saba also reported that they were embarrassed to obtain condoms from outlets managed or frequented by women. Non-use of vasectomy was attributed to poor access to the method, inadequate knowledge about it, irreversibility, access to alternative methods, and desire for more children. In spite of low rates of use for male methods, there is the potential for greater involvement of men

in family planning in Kibera and Nairobi. For instance, some 10% of men reported a willingness to use vasectomy if it were available. Over two-thirds of men in both areas had discussed contraceptive use with their wives, and a majority of male non-users in both districts reported the intention to use a family planning method in the future.

52 CONCLUSION

The study findings and discussions lead to the following conclusions:

The respondent's knowledge on family planning was quite high. The mass media was found to be the first and most common sources of family planning information. Most of the respondents wanted more information on family planning and most of the respondents, three-quarters discuss family planning with their wives. However, men mostly make the decision on family planning. A quarter of the respondents feared their wives practicing family planning. The fears included; infidelity and lack of respect for them. More than two-thirds of the respondents said avoiding pregnancy is the responsibility of women. However majority of them makes decision on family planning. Almost a quarter of them does not approve of male contraception, those who approved, said the condom was the most ideal for them. About one-quarter of them are not currently using a method with their wives. The reasons given include: intend to get another child. Religion, not yet decided, health reasons and wife disapproves. Slightly less than a third would like their wives to use contraceptives.

5.3 Recommendations

Men's knowledge of, and expressed interest in, family planning methods is generally high in the study area therefore, more emphasis on men's participation in reproductive health is mandatory.

Improve the quality and quantity of information to allay fears, rumors, and wrong information associated with specific family planning methods, such as condoms and vasectomy.

Intensify programme outreach and initiate male motivational campaigns possibly through print, electronic media, barazas, and dramas or concerts.

Encourage family planning discussions possibly through male female peer group information sharing networks to facilitate discussion of family planning among couples.

Increase the range of family planning services available to men possibly through male-only clinics, where information and services such as vasectomy could be provided.

Promote condom use possibly through social marketing and distribution at places appropriate and convenient for men.

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APPENDIX 1 :INTERVIEWER SCHEDULE FOR MARRIED MEN ON MODERN FAMILY PLANNING

The information collected is for research purposes and will be treated with all confidentiality. So Jeel free to share the information with us.

Number of interviewer

Date of interview

Name of residence

PART A: BACKGROUND INFORMATION

Q 1. What is your age? (Years)

Q2. What is your marital status?

1. Married

2. Widowed

Q3 For how many years have you been married?

1. Less than 2 years

2. 2- 5years

3. 6-10years

4. over 10years

Q4 How many wives do you have?

1. 1

2. 2

3. More than two

Q5 is your wife/wives staying with you?

1 Yes

2. No

Q 6 How many children do you have?

1- 1-2

2. 3-4

3. 5-6

4. 7 and above

Q" Educational level

1. None

2. Primary

3. Secondary
4. College
5. University

Q8. Occupation

1. Employed
2. Casual laborer
3. Self Employed
4. Others (Specify) ...

Q9 Religion

1. protestant
2. catholic
3. Muslim
4. others

PART B: KNOWLEDGE

1. What is family planning?

1. Don't know
2. Getting few children
3. Spacing of children
4. Getting the number of children one can support

2. What is the benefit of family planning to you and your family?

1. Don't know
2. Better health
3. Less work/less burden
4. More time with children; parents
5. Able to provide for children needs
6. Others specify

3. Which is your main source of information on family planning?

1. Radio.
2. Health workers.
3. Schools
4. Neighbours/friends

- 5. Barazas
 - 6. Posters and magazines
 - 7. Others (specify)
4. Would you want more information on family planning?

- 1. Yes
- 2. No

PART C: ATTITUDE

Q1. Have you ever discussed family planning with your wife?

- 1. Yes
- 2. No

Q2. If yes, who started the discussion?

- 1. Me (husband)
- 2. My wife

Q3. Who makes the decisions on family planning within the family?

- (1) Myself
- (2) My wife
- (3) Both of us

Q4. Do you fear your wife practicing contraception?

- (1) Yes
- (2) No

5. If yes, what are your fears?

- (1) Infidelity
- (2) Lack of respect for me
- (3) Fear of AIDS

6. How many children would you want if you were to have an ideal family size?

(DI-2)

- (2) 3-4
- (3) 5-6
- (4) As many as per income

How would you determine your family size?

- 1. Income

2. Presence of a boy
3. Presence of both boys and girls
4. Mother's health status
5. Others (specify)

S. Who is responsible for avoiding pregnancy in a marriage?

1. Women
2. Men
3. Both

9 Do you approve of male contraception? 1. Yes

2. No

10. If yes, which one?

1. Condom
2. Vasectomy
3. Others (specify)

11. Which is the best method (way) of delivering family planning messages for men?

1. Radio
2. Male gathering
3. Health workers
4. Posters'magazines

PART D: PRACTICE

1. Have you ever used any form of male contraception?

- (1) Yes
- (2) No

2. If yes. which one?

- 1 Condom
2. Vasectomy

3. Are you and your wife currently using any family planning method?

- 1 Yes
2. No

4. If yes, which method are you using?

- (1) Pill

- (2) Injectable
- (3) Intra-uterine device
- (4) Condom
- (5) Tubal ligation
- (6) Spermicides
- (7) Vasectomy
- (8) Natural family planning
- (9) Norplant
10. Others specify

5. If not using a method, why?

- (1) Intend to have another child
- (2) Lack of knowledge on methods
- (3) Health reasons
- (4) Religion
- (5) Wife disapproves
- (6) Not yet decided
- (7) Others (specify)

APPENDIX 2

FOCUS GROUP DISCUSSION FOR MARRIED MEN IN KIBERA LAINI SABA

Climate setting by moderator

- self introduction
- aim purpose of discussion

(1) What is family planning?

(2) What are the benefits of family planning to you and your family?

(3) What are the various methods of family planning?

•i Have you ever used any form of contraception?

5) If yes, which one?

'6' Do you intend to use a method in future?

(7) If yes which one?

i8i How many children would you want if you were to have an ideal family size?

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