

**BARRIERS TO MALE INVOLVEMENT IN FAMILY PLANNING IN KIAMBU  
COUNTY, CENTRAL KENYA**

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## **DECLARATION**

This research paper is my original work and has not been submitted for examination to any other university.

Signature\_\_\_\_\_

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(N69/74684/2014)

This research paper has been submitted for examination with my approval as the university supervisor.

Signature\_\_\_\_\_

Date\_\_\_\_\_

Dr. Dalmas Omia

## TABLE OF CONTENT

<b>DECLARATION</b> .....	<b>ii</b>
<b>LIST OF FIGURES</b> .....	<b>iv</b>
<b>LIST OF TABLES</b> .....	<b>v</b>
<b>DEDICATION</b> .....	<b>vi</b>
<b>ACKNOWLEDGEMENT</b> .....	<b>vii</b>
<b>LIST OF ABBREVIATIONS AND ACRONYMS</b> .....	<b>viii</b>
<b>ABSTRACT</b> .....	<b>x</b>
<b>1.0 CHAPTER ONE: BACKGROUND TO THE STUDY</b> .....	<b>1</b>
1.1 Introduction .....	1
1.2 Problem Statement .....	5
1.3 Objectives of the Study .....	6
1.3.1 Overall Objective.....	6
1.3.2 Specific Objectives .....	6
1.4 Assumptions of the Study.....	6
1.5 Justification of the Study.....	7
1.6 Scope and Limitations of the Study .....	8
1.7 Definition of Key Terms .....	9
<b>2.0 CHAPTER TWO: LITERATURE REVIEW</b> .....	<b>10</b>
2.1 Introduction .....	10
2.2 Overview of Family Planning in Kenya.....	10
2.3 Male Involvement in Family Planning Initiatives.....	12
2.4 Barriers to Male Involvement in Family Planning.....	13
2.4.1 Cultural Factors .....	13
2.4.2 Economic Factors .....	17
2.5 Theoretical Framework .....	19
2.5.1 Social Exchange Theory.....	19

2.5.2 Social Cognitive Theory .....	20
2.5.3 Relevance of the Theories to the Study .....	21
<b>3.0 CHAPTER THREE: METHODOLOGY.....</b>	<b>23</b>
3.1 Introduction .....	23
3.2 Research Site .....	23
3.3 Research Design .....	24
3.4 Study Population and Unit of Analysis .....	24
3.5 Sample Population and Sampling Procedure .....	25
3.6 Data Collection Methods.....	25
3.6.1 Semi-Structured Interviews .....	25
3.6.2 Key Informant Interviews.....	26
3.7 Data Processing and Analysis .....	27
3.8 Ethical Considerations.....	27
<b>4.0 CHAPTER FOUR: BARRIERS TO MALE INVOLVEMENT IN FAMILY</b>	
<b>PLANNING .....</b>	<b>29</b>
4.1 Introduction .....	29
4.2 Demographic Characteristics of Respondents.....	29
4.2.1 Age of Respondents.....	29
4.2.2 Respondents Length of Stay in Marriage .....	31
4.2.3 Respondents Highest Level of Education.....	32
4.2.4 Religious Affiliation of Respondents .....	33
4.2.5 Occupation of Respondents .....	34
4.2.6 Respondents Average Monthly Income .....	35
4.2.7 Respondents Source of Information About Family Planning.....	36
4.3 Barriers to Male Involvement in Family Planning.....	38
4.3.1 Cultural Barriers to Male Involvement in Family Planning .....	38

4.3.2 Economic Barriers to Male Involvement in Family Planning .....	46
<b>CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS .....</b>	<b>50</b>
5.1 Introduction .....	50
5.2 Summary .....	50
5.3 Conclusion.....	51
5.4 Recommendations .....	52
5.5 Suggestions for Further Research.....	53
<b>REFERENCES.....</b>	<b>54</b>
<b>APPENDICES .....</b>	<b>60</b>
Appendix I: Written Consent Form.....	60
Appendix II: In-Depth Interview Guide.....	62
Appendix III: Key Informant Interview Guide .....	62

## **LIST OF FIGURES**

Figure 3.1 A map showing Kiambu County with all its sub-counties.....	23
Figure 4.1 Age of Respondents.....	30
Figure 4.2 Respondents Highest Level of Education.....	32
Figure 4.3 Respondents Average Monthly Income.....	35
Figure 4.4 Respondents Source of Information About Family Planning.....	36

**LIST OF TABLES**

Table 4.1 Respondents Length of Stay in Marriage.....31

Table 4.2 Religious Affiliation of Respondents .....33

Table 4.3 Occupation of Respondents.....34

## **DEDICATION**

First, my warmest and greatest gratitude goes to my parents, for it is by their grace, mercy and provision that I was able to go through with my studies. This research paper is therefore, dedicated to my family for their support and encouragement throughout the study period. To the God almighty, I am indebted to you for the good health, energy and capability to undertake my studies.



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## LIST OF ABBREVIATIONS AND ACRONYMS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>CPR</b>	Contraceptive Prevalence Rate
<b>FP</b>	Family Planning
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICPD</b>	International Conference on Population and Development
<b>IMNCS</b>	Improving Maternal Neonatal and Child Survival
<b>IPPF</b>	International Planned Parenthood Federation
<b>KDHS</b>	Kenya Demographic Health Survey
<b>KNBS</b>	Kenya National Bureau of Statistics
<b>MAP</b>	Men As Partners
<b>MDG</b>	Millennium Development Goal
<b>MMPP</b>	Male Motivation and Planned Parenthood
<b>NGOs</b>	Non-Governmental Organizations
<b>OPAC</b>	Office of Population Affairs Clearing House
<b>PPASA</b>	Planned Parenthood Association of South Africa
<b>SRH</b>	Sexual Reproductive Health
<b>TFR</b>	Total Fertility Rate
<b>UN</b>	United Nations
<b>UNDP</b>	United Nations Development Programme

<b>UNFPA</b>	United Nations Population Fund
<b>UNIDO</b>	United Nations Industrial Development Organization
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

## **ABSTRACT**

This is a cross-sectional descriptive study on barriers to male involvement in family planning in Kiambu County, Central Kenya. The specific objectives of the study include; describing cultural and economic factors that impedes male involvement in family planning, and establishing the extent to which cultural and economic factors impede male involvement in family planning initiatives in Kiambu County. The study is premised on the social exchange theory and social cognitive theory. The study was conducted with 60 married men aged between 18 and 55 years who were purposively sampled. Data was collected through semi-structured interviews and key informant interviews and analyzed through grounded approach in line with specific objectives.

The findings indicate that social factors such as religion, knowledge on FP, gender roles and spousal communication influence male involvement in family planning. Further, majority of married men in Kiambu County have never been involved in any FP project design activities, thus are locked out from involvement. In addition, married men in Kiambu County do not consent to the use of modern FP methods and they are only limited to the use of male condom which is widely known and accepted by many. From the study, Economic factors such as income and unmet need for FP also influence male involvement in FP in that, married men who earn less than KES 10,000 per month in Kiambu County find it too expensive to procure modern FP methods thus prioritizing their income to other necessities.

The study recommends that since men shows a positive attitude towards FP, the government and other stakeholders should increase FP service accessibility and availability. FP service providers have to be well trained so as to increase and update married men with the knowledge of the modern FP methods. Community health workers should encourage creation of advocacy groups at community level aimed at leading households to cultural change towards FP services and encourage the uptake of FP services. In addition, the County Government should find a way of training people on debunking the myths especially male members of the household. Finally, the study suggests that a similar study be conducted in other parts of the country to enable a formulation of male involvement in FP policy and program in the whole county.

## **1.0 CHAPTER ONE: BACKGROUND TO THE STUDY**

### **1.1 Introduction**

The use of family planning methods is regarded as an important concern measure to women as it acts as a key factor in reducing poverty. As such, access to safe, voluntary family planning (FP) is considered as a human right. According to UNFPA (2014), although over 235 million women globally have the desire and drive to use safe and efficient FP methods, this philosophy does not resonate with that of their partners or communities thus, this is rendered almost impossible.

Most FP programmes and projects historically offered these services exclusively to women since they were viewed as the target group and paid little attention, if any, to the roles that men could have played. Stenberg and Hurley (2004) posit that in the 1980s, a majority of health promoters fostered on implementing sexual and reproductive health programmes that were designed for women empowerment and protecting them from the impact their male counterparts had on FP issues. However, Mehta *et al.* (2002) observes that only a few programmes made attempts to address and encourage male involvement in the use of FP methods such as vasectomy, condom use, and in the overall contraceptive use decision-making. As such, there has been a consensus that male involvement in family planning does not only help in the acceptance of contraceptives but, more importantly, it is efficient and of perpetual use (Mehta *et al.*, 2002). Therefore, irrespective of the wife considering the use of contraceptives, her desire may be rendered incapable by the husband through forced discontinuation especially when the husband does not approve of its use. The International Conference on Population and Development (ICPD) that took place in Cairo in 1994 dubbed “Program of Action” suggested the need for stakeholders to be involved to promote active involvement of men in family planning programmes (García-Moreno & Stöckl, 2009).

In the USA, for instance, the Office of Population Affairs Clearing House (OPAC, 2008) indicated that there is under development in reproductive health research on men compared to that of women. As a matter of fact, males receive fewer reproductive services compared to their female counterparts. According to a survey conducted by OPAC in 2002, only 30% of men aged 20-44 received sexual health services, i.e., birth control advice/services. Conversely, the USA conducted an initiative in over half of its states dubbed “The X Project” under the Medicaid program, which was geared at extending family planning programmes to both men and women who had otherwise not been covered by Medicaid (DHHS, 2008). This project involved men in family planning to achieve maximum success and sustainability of family planning initiatives.

According to Clark *et al.* (2008), Bangladesh has recorded poor utilization of family planning programmed services because all policies, activities, and projects are exclusively women-centred. It was further noted that most family planning field service delivery systems were female focused (Clark *et al.*, 2008). Husain (2003) argues that such a directive gives the male a very little opportunity to participate in family planning initiatives. A further study conducted by Noreen *et al.* (2012) found that men who were actively involved with Improving Maternal Neonatal and Child Survival (IMNCS) program were more likely to be involved in their partners reproductive health issues compared to those not involved in the project. This project actively involved men in family planning training and activities urging them to accompany their partners to FP sessions, thus encouraging their involvement (Nasreen *et al.*, 2012).

Khan and Patel (2001) report that the study of male’s role and involvement in family planning is a widely neglected area in India. However, in the previous 30 years the country had recorded a significant change in contraceptive use. In the 1960s and 1970s, the main acceptors of family planning methods such as the condom and vasectomy were males contributing to about 50% of

the total FP acceptors. However, technological advancement to other FP methods such as sterilization and laparoscopic contributed to the gradual shift towards women (Clark *et al.*, 2008). Conversely, Wang *et al.* (1996), after conducting a randomized study, found that there were lower contraception discontinuation rates in China. The study further indicated that there was an acceptable use of FP methods on partners who were both educated about FP compared to women who were taught in the absence of their husbands.

The trend is no different in Africa. In Malawi, a study by Sold an (2004) concluded that in many traditionally patriarchal settings, men dominate the decision-making with regard to family size and their partner's use of contraceptive methods. Similarly, Niota (2001) and Oyediran, Ishola, and Feyisetan (2002) posit that men in Sub-Saharan Africa are the primary decision makers as far as family planning and family size issues are concerned.

In South Africa, Peacock and Leak (2004) developed a programmed of collaboration between Engender Health and Planned Parenthood Association of South Africa (PPASA). The study aimed at working with men in promoting gender equity geared at fostering sexual and reproductive health for both men and women. Peacock and Leak (2004) embarked on this study due to the realization that the attitude and behavior that men have can either impede or promote sexual and contraceptive health (Peacock & Levack, 2004). Therefore, South Africa Men as Partners (MAP) programmed had the sole responsibility of encouraging positive male involvement in family planning.

According to Ajani and Kevel (1998), Kenya was one of the first African countries to recognize the importance of family planning as a core element in economic and social development. In the early 1960s, Pathfinder assisted in opening family planning clinics in both Mombasa and

Nairobi, which came to be regarded as the family health options in Kenya. KNBS (2014) indicate that Kenya has a total fertility rate of about 4.8% with 5.7% and 3.2% recorded for rural and urban areas, respectively. Despite modernization, and an increase in the FP methods, the rate of male involvement in the use of contraceptives is still small with condom use being as low as 15.2% (KNBS, 2010). There has been increasing attention by the World Health Organization (WHO) to improve constructive male involvement in the reproductive health. A study conducted by Hawks and Hart (2000) in Geneva found that reproductive health professionals are failing to target male involvement in reproductive health decision making and the use of health resources. Moreover, there has been limited knowledge of how to fully incorporate men in reproductive health programmes despite their participation in family planning decision making being thought as having some economic benefits (Hawkes & Hart, 2000).

Kenya is predominantly a patriarchal society and so men hold the ultimate power over family size decision-making. *Population Action International* (2010) suggests that regardless of the wish of many women to cease childbearing, their husbands most of the times determine whether such a desire will be fulfilled or not. A study conducted by APHRC (2013) found that about 43% of all pregnancies in Kenya are mostly unplanned and unintended since couples are not actively involved in the use of family planning services as they ought to. Moreover, the study concluded that men were not allowing or either were they willing to use male FP methods. Women in this study further highlighted that it was their wish to control birth rate via the use of family planning methods though they could not use it before warranting by their husbands (APHRC, 2013).

In this regard, this study aims at investigating barriers to male involvement in family planning in Kiambu County to understand the factors that continue to undermine more active participation.



## 1.2 Problem Statement

Ngetich (2013) argues that based on statistics there is need to intensify family planning programmes so as to reduce rapid population growth. Regardless of Kiambu County's strategic plan recognizing the existence of unequal participation by men and women in the County's population and development process, there exists no initiative in the sub-county designed at involving men in FP. Furthermore, regardless of various researchers suggesting that population control and management be an all-inclusive affair, the programmes, projects and activities being undertaken by the county government and NGOs in Kiambu County have largely excluded men (Ngetich, 2013).

GoK (2013) reports that in Kiambu County, knowledge on family planning among men stands at 22% compared to 78% of women. This is thus a clear indication that family planning initiatives have failed to target men in education and awareness creation. A study conducted by KARE (2012) in Limuru Sub-County found that only 18% of men were involved in family planning initiatives and that only 27% of men approve the use of contraceptives to their partners.

As much as numerous studies emphasize the benefits of men's involvement in the success of reproductive health and family planning programmes, there still exist research gaps on the specific factors that impede male involvement in family planning initiatives in central Kenya more so Kiambu County. Onyango *et al.* (2010), argue that there is a dearth of literature on factors which inhibit male involvement in reproductive health from the perspective of men themselves. A pilot project by the organization dubbed "Men Allied for Health and Non-Violence" (MAHN) has shown several challenges associated with male involvement in family planning. The pilot was largely unsuccessful based on the poor availability of information in best practices on involving men in FP initiatives. To address these research gaps, this study examined

barriers that hinder male involvement in family planning in Kiambu County with a view to highlighting its implications for future design, planning, implementation, evaluation and research of family planning reproductive health projects.

The study sought to answer the following questions;

- i. What are the cultural and economic factors that impede male involvement in family planning initiatives in Kiambu County?
- ii. To what extent do cultural and economic factors impede male involvement in family planning initiatives in Kiambu County?

### **1.3 Objectives of the Study**

#### **1.3.1 Overall Objective**

To explore barriers to male involvement in family planning in Kiambu County.

#### **1.3.2 Specific Objectives**

- i. To describe cultural and economic factors that impedes male involvement in family planning initiatives in Kiambu County.
- ii. To establish the extent to which cultural and economic factors impede male involvement in family planning initiatives in Kiambu County.

### **1.4 Assumptions of the Study**

- i. Predominant patriarchal values inhibit male involvement in family planning in Kiambu County.

- ii. There is a combination of cultural and economic factors that impedes male's participation in family planning in Kiambu County.

### **1.5 Justification of the Study**

Male's participation at all levels in the reproductive health and family planning programmes is regarded as a vital tool for achieving Kenya's Vision 2030. This study focused on filling the knowledge gap on the factors that constrain male involvement in family planning in Kiambu County. It aimed at bringing up male-sensitive research and development programmes to ensure their participation at all levels in the reproductive health and family planning programmes. It established that; FP programmes are not usually organized to target men thus rendering it hard in achieving a sustainable impact. Lack of regular spousal communication leads men into having a negative attitude towards the use of FP and reproductive health. Knowledge of FP poses a direct influence on male involvement in that, the more knowledgeable a man is on FP, the higher the possibility that he would be involved in the same, and that there is unmet need for FP services targeting men thus the absence of such services hinders their active involvement in FP.

The study was deemed important because the findings could be used by both the national and county governments as a basis of formulating policies that relate to family planning and reproductive health. Development experts, organizations and institutions especially those concerned with the implementation of vision 2030, Millennium Development Goals (MDGs) and other development blue prints in the sector of family planning and women empowerment would also find the results of the study useful in both review of the existing projects as well as designing, planning, implementing and evaluating future projects. Through the findings of this study, such stakeholders will be concerned with involving men from the designing, planning and implementation phases of FP programmes to ensure they achieve a sustainable impact. The study

will also be of great importance to other researchers and academicians who seek to understand the factors that hinder men's involvement in family planning and how these factors can be mainstreamed into the project cycle in achieving lasting impact. In addition, the community including households and families could also use the findings of the study to challenge themselves in advocating for the importance of male involvement in FP programmes and to adopt practices that can help them in embracing family planning.

### **1.6 Scope and Limitations of the Study**

This study was carried out in Kiambu County, Central Kenya specifically Kiambu Town. The target population was married men aged 18-55 years in which only 60 of them were sampled for the study where it was geared towards establishing the various barriers to male involvement in family planning. The study focused on knowledge, perceptions, practice, and attitudes on FP which are personal and sensitive. Efforts were however made by the researcher to reduce respondent's fear of being judged by assuring them of the confidentiality of all information provided. The study was further limited to male experiences. It did not focus on women since statistics show that male partners hardly participate in the reproductive health and FP programmes. Thus this study sought to establish this fact by pointing out the actual constraining factors. Conversely, the researcher believed that sampling men alone in the study will give valuable information for the scope of the study. The study was qualitative in nature, however, triangulation of data collection methods was aimed at ensuring that data collected is rich enough to answer to the study questions. In addition, the purpose of triangulation was to increase the credibility and validity of the results of this study. Moreover, the social exchange theory used by the researcher was only limited to the economic factors that make individuals rational but does not put cultural factors into consideration. Thus the researcher thought it was necessary to settle

for another theory i.e. the social cognitive theory which considers cultural aspects resulting into the adoption of new and different behaviors.

### **1.7 Definition of Key Terms**

**Family planning:** It is having a choice of the number of children in a family and the duration of time between the births of the children.

**Male Involvement:** The act of engaging men in the reproductive health and family planning services.

**Barriers:** Challenges/factors that pose complexities thus inhibiting male involvement in family planning.

**Culture/Traditions:** Beliefs, customs, practices and social behavior embedded in the community of Kiambu County.

## **2.0 CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Introduction**

This chapter presents literature review on the barriers to male involvement in family planning. The review was carried out with the following subheadings: male participation in family planning, and the cultural and economic factors that impede male involvement in family planning. The chapter ends with a discussion of the theories that guided the study.

### **2.2 Overview of Family Planning in Kenya**

According to the GoK (2013), the population of Kenya is classified as very young with two-thirds of the total population composed of young people below the age of 30 years while only 5% of the population is over 60 years. This is attributed to the persistent high fertility rate in the country (GoK, 2013).

Soon after Kenya attained her independence, the government considered it rational to control population for sustained economic development. The annual growth rate of about 3% made the government incorporate family planning strategies in 1965. In fact, Kenya became the first country in Sub-Saharan Africa to establish a National Family Planning Programme in 1967. In its quest to lower fertility rates further, the government continued making massive investments in family planning through the development of strategies, programmes, and policies arrived at addressing the population management challenges. As a matter of fact, this saw the government assenting to the global and regional agreements such as the Abuja Declaration, Maputo Protocol, Family Planning 2020 (FP2020), protocols and the ICPD. All these agreements require the government to allocate a given percentage of its annual budgets to the health sector. The Family Planning 2020 protocol is in support of the rights of both women and girls to freely decide on their own on the number of children they want. As such, the FP2020 works handily with

governments, donors, multilateral organizations, the private sector, civil societies, and research and development communities geared towards enabling over 120 million women and girls to use contraceptives by 2020 (Brown *et al.*, 2014). The current opposition posed by males to the use of family planning methods especially in traditional societies could, however, make this goal hard to realize.

The majority of studies all over the world indicate that women prefer having and running smaller families. According to the UNFPA (2011), over 100 million women globally would prefer avoiding pregnancy although they do not use any family planning methods. This indicates that there have been unmet needs for family planning up to date. In Kenya, for instance, the unmet need for family planning currently stands at 46% thus leading to women undergoing unsafe abortions as a result of unwanted pregnancies (UNFPA, 2011). In the last two decades, the population of Kenya has more than doubled, and the APHRC (2013) suggests that Kenya will experience perpetual rapid population growth. The United Nations Projections indicate that the people of Kenya will, by 2050, reach about 85 million (APHRC, 2013).

Irrespective of the government taking significant initiatives to increase access to family planning services, its use remains to be very low among many couples, those in the rural areas being the majority. This is attributed to the traditional family structure whereby men remain being considered as family heads and the entire decision-making in the family left to them (GoK, 2013). As much as it is the wish of every woman to cease bearing more children, their male counterparts do not allow them to do so while at the same time they are unwilling to use the available male family planning methods.

It is apparent that men's involvement in family planning has been conspicuously absent even among family planning organizations since there has been a perception that these services can damage the quality of a woman's services while at the same time creating competition for the now scarce resource. However, newer family planning programmes have a tendency of enhancing rather than depleting the existing ones so long as the people involved in their design would structure them in a way that it will be beneficial to both men and women (García-Moreno & Stöckl, 2009). The 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing both endorsed the incorporation of reproductive health services. The two conform to the fact that it is very essential to include men and make their constructive roles part of the broader reproductive health agenda (Levy, 2008).

Therefore, neglecting to provide information and services for men can detract from women's overall health. Men who are educated about sexual health issues are, for instance, more likely to support their partners in family planning decision-making and at the same time take up the responsibility of using contraceptives. Men need to share the responsibility for disease prevention, as well as the risks and benefits of contraception (Mehta *et al.*, 2002).

### **2.3 Male Involvement in Family Planning Initiatives**

Following the Cairo initiative that took place about two decades ago, there have been various efforts and attention put in place to increase male involvement in family planning services. However, there is no accepted understanding of a broad meaning of active male involvement in family planning that exists. According to Toure (1996), male involvement is defined as all activities targeted at increasing the number of men who use contraceptives (Toure, 1996). However, his definition is criticized by Greene (2000) who defines male involvement as all organizational activities targeted at men with the objective of increasing the number of men that



encourage and inspire their wives to use family planning services. Greene (2000) adds that it is influencing the policy environment to make it conducive for male-related programmes and not just increasing the number of men who use contraceptives. Nelson *et al.* (1996) suggest that the Cairo Action Plan defines male involvement in all activities that promote men's active participation in family planning activities, projects and programme services with the aim of achieving gender equality and empowering women (Nelson *et al.*, 1996).

As much as the above definitions attempt to highlight what male involvement in family planning initiatives entail, it is Mburu and Adam's (2011) definition that suffices in this study. The two scholars posit that male involvement involves all activities that are geared towards ensuring active participation and shared responsibility between both partners in family planning matters with the primary aim of providing joint decision-making on the use of contraceptives.

## **2.4 Barriers to Male Involvement in Family Planning**

### **2.4.1 Cultural Factors**

Levy (2008) suggests that the ability of a woman to control her fertility level is strongly affected by the social constructs of gender roles and expectations. An assortment of researchers indicates that gender inequality has a tendency of who uses, accesses, and makes decisions of contraceptives. Moreover, gender inequality determines when to participate and withdraw sex (Levy, 2008). These hurdles vary from one culture to the other although they are common to all cultures in the world, and they lead to adverse family planning health outcomes. In a patriarchy society, gender inequality would result in verbal and physical abuse to women. Research conducted by the Family Health International Women Studies in Bolivia and Philippines about the relationship between gender and family planning found that the use of contraceptives was a

factor in domestic violence. In the Philippines, 25% of the women reported having been physically abused by their husbands. In India, Char (2011) argues that since the society is male dominated, the acceptance and use of female sterilization is only significant based on the husband's decision (Char, 2011).

In Malawi, Paz Soldan (2004) found that men determine family size decision-making and the use of contraceptives. However, the study points out that male partners are always resistant to family planning initiatives. It further reports that fear of spousal retaliation due to disagreements about whether to use contraceptives or not as a major barrier to male involvement. The role of men in the family is quite in a contradictory state thus their decision-making role is detached from reproductive health issues, thereby posing immense challenges for their active involvement in family planning and contributing to low contraceptive prevalence rates in the African context (Paz Soldan, 2004).

Religion instigates different beliefs and norms surrounding sexuality issues. It is a powerful tool with the capability of swaying people's opinions as regards family planning. Most religions are against the use of modern contraceptives. According to Ali and Ushijima (2005), procreation is the primary purpose of marriages and sexual intercourse for Catholics. As such, the use of contraceptives violates the principal purpose of marriage. The majority of Islamic jurists in Swaziland indicate that the use of family planning is not forbidden. Others, on the other hand, suggest that family planning violates God's primary intention of marriage. Among fundamentalist Muslims, FP methods that are permitted are those that do not induce abortion and are reversible. Irreversible sterilization methods are not allowed. As such, this has left male Muslims with a condom as the only contraceptive, and it should strictly be used within marriage only (Ali & Ushijima, 2005). Sileo (2014) suggests that mobilization of family planning in

Uganda has been rendered difficult owing to the involvement of religious leaders. According to Izugbara *et al.* (2010), religious barriers are quite evident in African in that about 20% of the population is composed of Catholics whose doctrine emphasizes that sexual acts are for recreational purpose. Therefore, Catholics oppose any form of artificial methods (Izugbara *et al.*, 2010). Reports indicate that almost all religions in sub-Saharan Africa negatively impact the use of contraceptives making it hard for conservative males to be involved. In Lurambi constituency, it was reported that some religious leaders support the adoption of family planning while others oppose it, leaving men confused on whether to participate in contraceptives or not. Thus, the use of contraceptives is based on their conservative decisions.

According to Korra (2002) and Abdel and Amira (2013), the desire for women to use contraceptives is brought about by the rapid population growth which is characterized by high fertility rates, high birth rates, and low male contraceptive prevalence rates. In India, a study conducted by the National Family Welfare Programme found that only 27% of males were aware of the modern methods. The remaining proportion used the traditional methods (Abdel & Amira, 2013). They further noted that a higher percentage of rural men are less knowledgeable about the modern contraceptive methods compared to their urban counterparts. In Lesotho, a study by Oluwasanmi *et al.* (2011) among female university students on their awareness and barriers to family planning services found that 97.5% of the total study population was knowledgeable. In Ethiopia, on the other hand, Wubegzier and Alemayehu (2011) found that over 97% of married women were aware of pills and Depo-Provera methods. According to Okech *et al.* (2011), the number of contraceptives that a couple knows will dictate their use. This research reported that the majority of married men in Kenya are not aware of modern contraceptives. Thus, it remains a barrier to male involvement since this knowledge is absent to them. As such, there is a great fear

of side effects of contraceptive use among men. Ojaka (2008), and Balaiah *et al.* (2005), therefore, suggest that there is a great need to conduct further studies to ascertain the knowledge level on contraceptives in Kenya so as to determine the mean number of contraceptives known to men.

The extent to which cultural factors impede male involvement in family planning differs based on the social and cultural background of married men. According to Oyedokun (2008), males have a limited choice of contraceptives due to their personal beliefs, dislike, and perception of contraceptive costs and their side effects. Cultural factors contribute to higher extent barriers to male involvement in family planning as a result of several couples autonomy and age of the married couple. According to a study conducted in Nepal, there exists a significant association between male involvement in family planning and gender roles. An assortment of studies shows that a couple that increases their contraceptive use improve their social and cultural changes while at the same time reducing maternal and child mortality. Most studies indicate that culturally, most communities render it hard for a male to be involved in family planning because contraception would lead to sexual unfaithfulness among the taker. However, a study conducted in Lesotho among female university students indicate that the 10% who were unaware of modern contraceptives and where their male counterparts were also non-knowledgeable, chances of the spread of STIs and HIV could be high. Therefore, WHO (2010) is concerned about the reluctance of male involvement in family planning which may hinder its goal of reducing the AIDS epidemic by 26% by 2020. In Kenya, Okech (2011), Nzioka (2001) and Ngetich (2013) indicate that lack of male involvement may further increase maternal and child mortality rates making it hard for the government to achieve its Millennium Development Goal and Vision 2030 with regard to reproductive health and family planning.

### **2.4.2 Economic Factors**

Developing nations have high poverty rates. Highly populated countries are no exception as the per capita income is relatively small owing to the large population. In India, for instance, a study by Balaiah *et al.* (2005) indicates that only men earning at least Rs. 5000 were 2.3 times likely to use contraceptives. Kamal *et al.* (2013) found that in Bangladesh, the level of a couple's income influences male involvement in family planning. This study reports that about 45.5% of men whose income level was more than 10,000 taka per month would be involved in reproductive health and family planning. Oluwasanmi *et al.* (2011) further indicate that unemployed men have high levels of not participating in contraceptive use compared to the employed ones. In Sudan and Uganda, the research found that male involvement in family planning declined with the decrease in the level of a household's income (Oluwasanmi *et al.*, 2011). In Kenya, Abdel and Amira (2013) posit that rural areas are associated with low-income levels and thus use of modern contraceptives is substituted with traditional methods of which does not always hold.

The unmet need for family planning is associated with education level. Studies conducted by Ferdousi *et al.* (2010), Mehta *et al.* (2002) and Hossain (2003) in India, Pakistan and Bangladesh, respectively, found that the level of education couples have contributed to their use of contraceptives. As such, the higher the level of education, the higher the rate of contraceptive use. A study conducted in southern Sudan reported that the unmet need for family planning decreases with the level of a married couple's educational achievement and employment status. Abdel and Amira (2013) posit that this happens as men become more and more empowered. In Uganda, studies show that the unmet need for family planning is lower for men with better education. For example, a study by Assefa and Fikrewold (2011) found that in, unmet need was less for men with at least secondary education. In Kenya, the same study reported that men with

incomplete primary education were two times more likely to experience an unmet need for family planning in comparison to those with complete primary education or higher education. Ojaka (2008), however, reports that, in most times, a husband's education is insignificant and suggests that the level of a wife's education is the most important if couple's unmet need was to be reduced.

Research by the Guttmacher Institute (2008) in the US reports that developing countries still lavish in poverty owing to their high population rates. According to the World Population (2004), poorer couples have a tendency of having children at a relatively younger age as compared to the wealthy ones. Moreover, this study found that poorer couples have more children throughout their lives compared to wealthy couples. Conversely, the use of modern contraceptives is only evident among wealthy couples. Thus, poorer couples are left enshrined to the traditional contraceptive use where at most times males are reluctant to adopt. Therefore, consequences that are associated with lack of male involvement in family planning persist in such households.

USAID (2011) reports that in such countries, one in every seven married men have an unmet need for contraception. In sub-Saharan Africa, however, the ratio stands at 1:4. Acayo (2012) conducted a study in Uganda's Lamwo district to determine economic factors that affect men in family planning utilization with their partners. The study found that about 18% were students, 39% were unemployed and 24% were operating small businesses. Employed men in the study accounted for only 16%. Acayo (2012) concluded that a majority of men could not afford family planning services owing to their economic status. Thus, this makes it hard for male involvement in family planning initiatives. Moreover, the study found that poverty has an adverse effect of contributing to further unwanted pregnancies, as well as high maternal and child mortality rate.

Also, even for wealthy women whose husbands are not that rich, only one out of five married women have an unmet need for family planning. This is because, in patriarchal society, men feel that it is their responsibility to provide for their families and if they cannot afford to buy contraceptives, then they will prevent their wives from doing so. But by the time they can procure contraception services, the damage has already occurred.

Ojaka, 2008 conducted research in Kibera slum in Kenya, which established that the income levels of married couples severely affects their use of contraceptives. The study found that 23% of the 115 unemployed respondents used contraceptives while only 48% of the 240 employed were on contraception. Therefore, Ojaka (2008) concluded that income level among married couples is a crucial determinant of male involvement in family planning.

## **2.5 Theoretical Framework**

### **2.5.1 Social Exchange Theory**

Social exchange theory was formally developed by Thibaut and Kelley (1959) and advanced in the 1960s by sociologists Homans (1961) and Blau (1964). This theory focuses on the rational assessment of self-interest in human social relationships. Social exchange theory provides scholars with an economic metaphor to social relationships. According to this theory, the fundamental principle is that humans in any social setting have a tendency of choosing those behaviours that maximize their likelihood of meeting self-interest in their enshrined situations (Cook *et al.*, 2013).

The social exchange theory is based on four assumptions. First, the theory assumes that individuals are rational and that they regularly engage in the calculation of costs and benefits in their social exchange. Secondly, those involved in interactions are rationally seeking to

maximize their individual needs and interests. Third, the rewards that a person accrues dictate his pattern of social interactions. Finally, the theory assumes that individuals participate in a relationship out of a sense of mutual benefit rather than coercion (Cook *et al.*, 2013).

Based on the social exchange theory, human behaviour is in such a situation that it is motivated by the desire to seek rewards and avoidance of potential costs in social situations. As such, humans choose rationally on the more beneficial social behaviours. Since social practices are costly, humans have a tendency of choosing only those behaviors that have high rewards (Cropanzano *et al.*, 2002). However, the Social Exchange Theory fails to explain the importance of community solidarity in its emphasis on individual need for male involvement in the fulfillment of FP. The framework of this theory can be viewed as valuing the separative self to the extent that rationality and self-interest are emphasized. By prioritizing this value, the connected self is overlooked and undervalued. The notion of people calculating their individual self-interest apart from communal formed the basis of the researcher focussing attention to another theory i.e. the Social Cognitive Theory that would discuss how people collectively learn to adopt to behavioral changes.

### **2.5.2 Social Cognitive Theory**

Bandura developed the social cognitive theory in 1986. This theory posits that the process through which people learn to adopt new behaviours includes gaining knowledge of the risks and benefits of behavior change. Moreover, the theory suggests the importance of assessing outcome expectations, overcoming social and structural perceived impediments to health behaviour change (Bandura, 1986).



A study conducted by Ankomah *et al.* (2011) in Nigeria found that misinformation about family planning has an adverse effect on contraceptive use while accurate information has a positive impact on its use. The study further reports that myths and misinformation have a tendency of negatively relating to contraceptive use including the belief that women become promiscuous, contraception is expensive, and that contraception is associated with cancer (Ankomah *et al.*, 2011). Other studies point out that accurate knowledge is positively associated with increased intention and use of contraceptives.

### **2.5.3 Relevance of the Theories to the Study**

Social exchange theory takes into account economic factors that make individuals rational. It argues that individuals have a tendency of choosing social relationships that are relatively cheap but with high payoffs. Thus the study used social exchange theory to assess the economic factors that impede male involvement in family planning making them rational consumers of family planning services. When there is a campaign on the use of contraceptives, men will embark on weighing the costs and benefits associated with the family planning method at their disposal. The theory, however, does not consider cultural factors thus making it limiting in that area. As such, the researcher settled on the importance of another theory that puts cultural factors into consideration.

The social cognitive theory considers cultural aspects such as myths, taboos, and beliefs that communities embrace making them to adopt new and different behaviours. As such, the theory explains reasons of any abrupt behavioral changes. The theory states that when people observe a model performing a behavior and the consequences of that behavior, they remember the sequence of events and use this information to guide subsequent behaviors. Observing a model can also prompt the viewer to engage in behavior they already learned. In other words, people do

not learn new behaviors solely by trying them and either succeeding or failing, but rather, the survival of humanity is dependent upon the replication of the actions of others. Depending on whether people are rewarded or punished for their behavior and the outcome of the behavior, the observer may choose to replicate behavior modeled. This theory, therefore, was relevant to the study as it was useful in explaining the cultural factors that impede male involvement in family planning.

### 3.0 CHAPTER THREE: METHODOLOGY

#### 3.1 Introduction

This chapter describes the research site, design, study population, sample and sampling procedure, data collection methods, as well as data processing analysis. The chapter concludes by discussing the ethical considerations that guided the study.

#### 3.2 Research Site

Kiambu County is a County in the Central Region of Kenya. Kiambu County is ranked fourth after Nairobi, Kakamega, and Bungoma Counties regarding the population size with its population standing at 1,896,490. Its population size, coupled with a total fertility rate of about 5.3%, which is 0.7% higher than national fertility rate of 4.6% (KNBS, 2010). Kiambu County is envisioned to be experiencing immense challenges associated with population change. As such, family planning programmes ought to be intensified so as to reduce the rapid population growth.



### **Figure 3.1 A map showing Kiambu County with all its sub-counties**

### **3.3 Research Design**

This was a cross-sectional and descriptive study using qualitative data collection methods. The researcher began with semi-structured interviews, followed by key informant interviews conducted with Doctors, Nurses and Clinical Officers in Kiambu District Hospital and finally case narratives conducted with some elders whom the researcher believed have robust knowledge necessary for the study. All study participants were purposively selected and recruited from Kiambu County.

Descriptive design involves acquiring information about one or more groups of people – perhaps about their characteristics, opinions, attitudes, or previous experiences – by asking them questions and tabulating their answers. According to Kombo and Tromp, (2006), descriptive research involves the description of state of affairs as it exists. Orodho (2003) adds that descriptive survey is a method of collecting information by interviewing or administering questionnaire to a sample of individuals. The ultimate goal is to learn about a large population by surveying a sample of that population. In this study, the descriptive design was chosen owing to its versatility, efficiency, and generalizability. In addition, this method lends itself to probability sampling from large population. The data collected was analyzed in line with the study objectives. Verbatim quotes have been used alongside presentation of the findings to project the voices of the informants.

### **3.4 Study Population and Unit of Analysis**

The study population comprised married men residing in Kiambu County aged between 18 and 55 years. Those who indicated that they are single were automatically excluded in the study

while those men who said they were married qualified the requirements of the study and preceded to the next stage in data collection. The unit of analysis was the individual married man.

### **3.5 Sample Population and Sampling Procedure**

Amin (2005) describes a sample as elements of a population that is subjected to the research questions. According to Babbie (2001), working with a sample reduces the length of time needed to complete research, cuts cost, is manageable and is almost a mirror of the entire population. In this study, 60 married men were purposively sampled in different parts of Kiambu aged between 18-55 years for semi-structured interviews and case narratives interviews.

Purposive sampling technique was used to sample the men to participate in the survey. According to Moore and McCabe (2006), purposive sampling technique is a type of non-probability sampling that is most effective when one needs to study a certain cultural domain with knowledgeable experts within. It is meant to reach a targeted sample quickly and renders it easy for the researcher to get a sample of subjects with specific characteristics. Additionally, researchers are able to draw on a wide range of qualitative research designs. This method has been chosen based on its ability to offer a wide selection of non-probability sampling techniques, thus making the findings generalizable to the population.

### **3.6 Data Collection Methods**

#### **3.6.1 Semi-Structured Interviews**

These were conducted with 60 married men drawn from Kiambu County. The interviews were semi-structured in a way that allowed for further probing. According to Bernard (1988), semi-structured interviewing is best used when you won't get more than one chance to interview

someone and when you will be sending several interviewers out into the field to collect data. The semi-structured interview guide provides a clear set of instructions for interviewers and can provide reliable, comparable qualitative data. Semi-structured interviews are often preceded by observation, informal and unstructured interviewing in order to allow the researchers to develop a keen understanding of the topic of interest necessary for developing relevant and meaningful semi-structured questions. Open ended questions were contained in the semi-structured interview guide to generate more information on the subject matter of the study (Appendix 2).

### **3.6.2 Key Informant Interviews**

These were conducted with six selected key respondents selected on the basis of their knowledge of the subject matter. The key informants included medical personnel (Doctors, Nurses and Clinical Officers) from Kiambu District Hospital and Community Elders aged 50-55 years drawn from Kiambu County. Prior to the actual data collection, the researcher wrote to the key informants requesting for their consent to participate in the study. Upon consenting to participate in the study, the researcher thoroughly explained to them the objectives and purpose of the study. They openly discussed their opinions with regards to barriers to male involvement in family planning and no personal information in the form of names or other identifying data were obtained from them. They noted that men in Kiambu County are less informed when it comes to FP and reproductive health and that there is a shortage of FP methods/devices targeting men thus hindering them from active involvement. A key informant interview guide (Appendix 3) was used to collect the data.

### **3.7 Data Processing and Analysis**

Data collected from semi-structured interviews, key informant interviews and case narratives was transcribed then coded. The data collected were checked, screened for completeness and accuracy as they were played in mp3 audio format. The researcher edited, coded and classified the data to ensure a meaningful relationship. Once the researcher was done with transcribing, what followed was exporting text as a .doc file to the computer which was ready for analysis. Analysis of the transcriptions followed in line with the specific study objectives as the main themes where the relationship between male involvement (Dependent variable) and the independent variables (Cultural and Economic factors) was examined.

### **3.8 Ethical Considerations**

Rensik (2011) defines ethical considerations as principles that protect the rights of participants in a research study. They are actions taken to ensure that the safety and rights of participants are not violated during the entire process of the study. According to Shamoo and Resnik (2009), these standards include voluntary participation, informed consent, confidentiality of information, anonymity of research participants and approval from relevant authorities to undertake research studies. The researcher obtained authorization for the study from the National Commission for Science, Technology and Innovation (NACOSTI/P/16/88511/11401) and reported to the County Commissioner and County Director of Education, Kiambu County prior to conducting the research project. Moreover, before embarking on this study, ethical clearance was obtained from the UoN-KNH Ethical Review Board (KNH-ERC/RR/519). During field work, the researcher gave an explanation to the respondents on the voluntary nature of the study and hence the freedom of withdrawal at will. A consent form obtained from the Institute of Anthropology Gender and African Studies of the University of Nairobi (Appendix 1) was used to obtain the

approval of the respondent's participation in the study. To ensure anonymity, the researcher used unique codes in the coding of data. The respondents were also assured of the confidentiality of the information they shared.



## **4.0 CHAPTER FOUR: BARRIERS TO MALE INVOLVEMENT IN FAMILY**

### **PLANNING**

#### **4.1 Introduction**

This chapter presents findings of the study which have been discussed under thematic subsections in line with the objectives of the study. The thematic areas include demographic characteristics of respondents, the influence of cultural factors to male involvement in family planning and the influence of economic factors to male involvement in family planning.

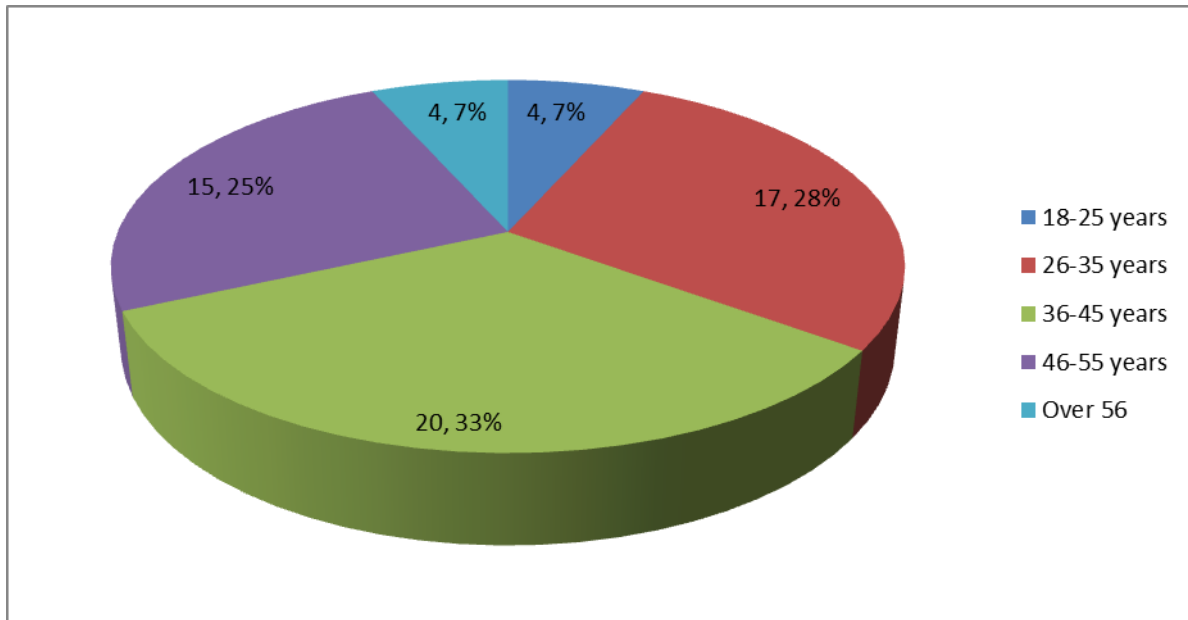
#### **4.2 Demographic Characteristics of Respondents**

The presentation has been carried out along the following demographic characteristics: Age, length of stay in marriage, level of education (primary, secondary, tertiary college, university and none), religious affiliation, occupation, average monthly income and source of information on family planning.

##### **4.2.1 Age of Respondents**

In the study, age of respondents was deemed an important aspect because this could determine their level of experience in family planning matters and their need for family planning services and information. The age of respondents could also reveal the level of commitment and responsibilities they had in their marriage or sexual relationships. The findings deemed that; the majority of the respondents were aged between 36 and 45 years forming 33% of the total responses. Moreover, those who were between 26 and 35 years represented 28%. In addition, those who were between 46 and 45 years were 25% while the minority was aged 18-25 and over 56 years.

The findings are summarized in figure 4.1 below.



**Figure 4.1 Age of Respondents**

Based on the statistics, it appears that the majority of those who participated in the study were in the young bracket. This was considered a suitable group in the analysis of factors hindering male involvement in family planning in Kiambu County, partly because of their sexual activity and suitability of being considered a good target group for family planning programs, projects and activities as explained by one of the respondents.

*“In this current generation, FP is a thing for the young people who are concerned with the well-being of their families. It is quite hard to see us the older people practicing it since our wives have reached menopause stage (SSI#8Male55years).”*

Since majority of the respondents were in the young bracket, it means that FP is of great concern to them unlike older people. However, age could have been a limiting factor for their active involvement in FP due to stigma and lack of better FP services at public health facilities. This is in line with the finding of the Kenya Demographic and Health Survey 2008-09 in which 68% of the respondents were the majority aged between 30 and 40 years (KNBS, 2010).

#### 4.2.2 Respondents Length of Stay in Marriage

The study deemed it important to understand the respondent's length of stay in marriage so as to explore the level of possible sexual activity and need for family planning services and information. In order to capture this very important information, the respondents were asked to mention their approximate length of stay in marriage. The findings established that; of the 60 respondents, 87% were married representing the majority of the responses. Of the 52 respondents who were married, the majority had been married for between 5 and 10 years (52%). Conversely, those who were married between 2 and 5 years represented 20%. Moreover, between 10 and 15 years represented 17% and the minority being married for over 15 years at 3%. From the results in table 4.1, it is clear that the majority of the respondents were married for a length of between 5 and 10 years, thus in active sexual relationship. The findings are summarized in table 4.1 below.

**Table 4.1 Respondents Length of Stay in Marriage**

<b>Years</b>	<b>Frequency</b>	<b>Percentage</b>
Less than 2 years	4	8
2-5 years	10	20
5-10 years	27	52
10-15 years	9	17
Over 15 years	2	3
<b>Total</b>	<b>52</b>	<b>100</b>

This proposition was important in the analysis of barriers to male involvement in family planning mainly because of their sexual activity as was remarked by one of the respondents.

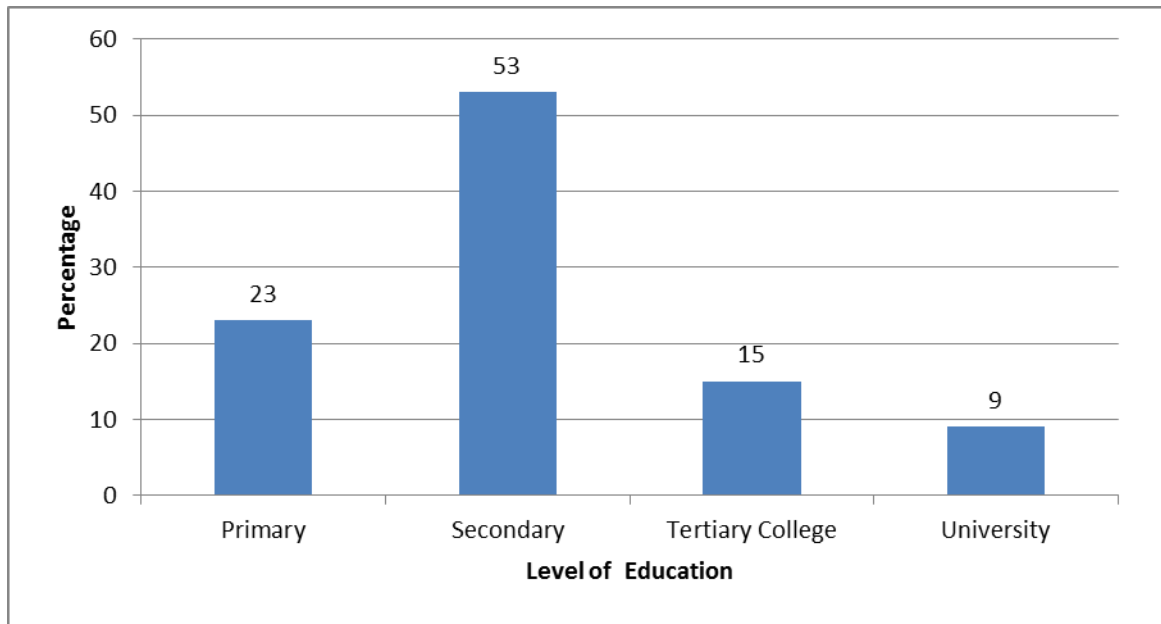
*“I tend to believe that FP is widely practiced by the young couples and therefore, I wouldn't be surprised to later on read your report and find out that they are the majority (SSI#12Male28years).”*

On the same, it is apparent that mobilization of FP is usually done on young couples since they are the greatest seekers of such programs. The findings of this study are in line with the findings of a study conducted by Sileo (2014) in Uganda whereby he concluded that mobilization of FP programs was majorly done on young couples with a range of 5-10 years length of marriage.

#### **4.2.3 Respondents Highest Level of Education**

The study sought to establish the level of education of the respondents. Level of education was considered important in this study because it could reveal information in the role of level of education in influencing male involvement in family planning among the study population. The researcher believed that level of education determined the respondent's exposure to information and world views. The study deemed that; of the 60 respondents, 53% of the respondents had secondary school education as their highest level of education. Moreover, those with primary education stood at 23%. In addition, those with tertiary education represented 15% while those with university education were 9% of the respondents.

The respondents were asked to state their highest level of education. Their responses are summarized in figure 4.2.



**Figure 4.2 Respondents Highest Level of Education**

The results of this figure generally shows that a majority of the respondents 53% had attained post primary education, thus were literate on FP and reproductive health as was remarked by one of the community elders;

*“Ever since the Government introduced free primary and secondary education, it has since been easy and economical to access education thus raising our people’s literacy level (KII#3CommunityElder).”*

These findings corroborate the findings from a study in Bangladesh that showed that a higher literacy level among men would increase their involvement in family planning and reproductive health from 40% to 78% (Kamal *et al.*, 2013).

#### **4.2.4 Religious Affiliation of Respondents**

The study also sought to establish the religious affiliation of respondents. This was considered important as religion could influence the position one held in regards to the issues of

involvement in family planning. From table 4.2, the study results show that the majority of the respondents were Protestants at 63%. Catholics 25%. Muslims 7%. While those who had no religion were the minority at 5%. To establish this important demographic characteristic, the respondents were asked to state their religious affiliations as summarized in table 4.2 below.

**Table 4.2 Religious Affiliation of Respondents**

<b>Religion</b>	<b>Frequency</b>	<b>Percentage</b>
Protestant	38	63
Catholic	15	25
Muslim	4	7
None	3	5
<b>Total</b>	<b>60</b>	<b>100</b>

One of the respondents indicated that;

*“Kiambu is a religious County. I see so many churches around and just a few mosques. So I tend to think that Protestants must be more than the other religions (SSII#12Male47years).”*

The findings of this study are in line with those by Schenker, (2000) which reported that Protestants are in no way prohibited by their religion to practice FP unlike the religious restricts that both Muslims and Catholics face.

#### **4.2.5 Occupation of Respondents**

The study also sought to establish the occupation of respondents. Occupation of the respondents was considered important as it would indicate whether or not each have time and resources

needed to be actively involved in family planning. From table 4.3 below, majority of the respondents were business persons at 55%. 20% were employed. 13% were unemployed. While the minority were students at 12%. Table 4.3 below summarizes this demographic characteristic.

**Table 4.3 Occupation of Respondents**

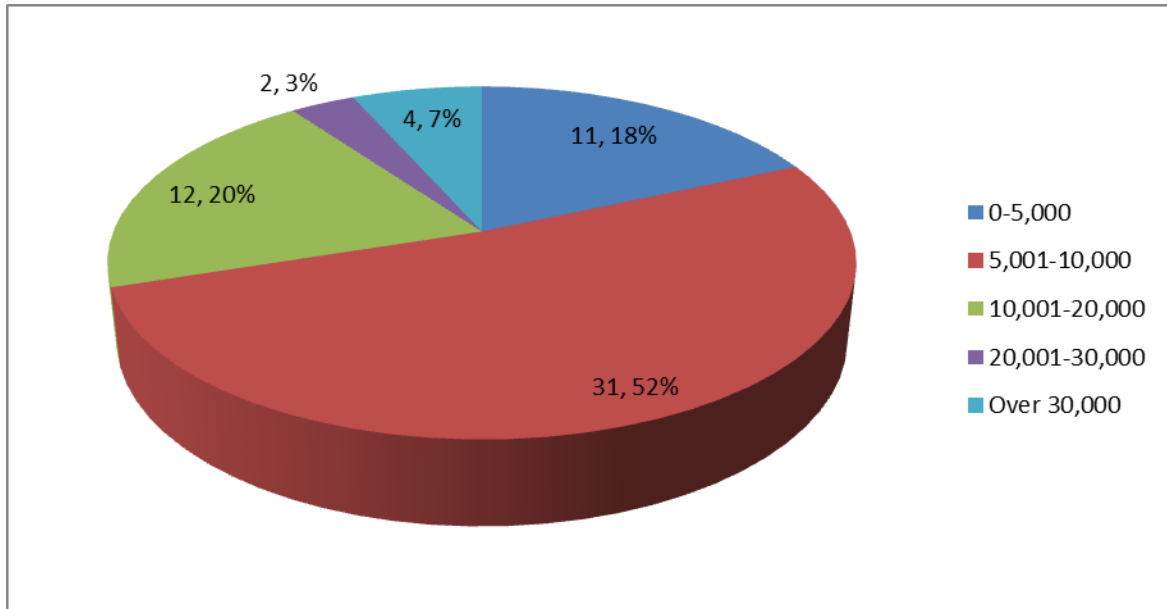
<b>Occupation</b>	<b>Frequency</b>	<b>Percentage</b>
Student	7	12
Employed	12	20
Unemployed	8	13
Business	33	55
<b>Total</b>	<b>60</b>	<b>100</b>

*“I have noticed that nowadays people are quitting employment at the expense of pursuing business. The best thing about business is that you become your own boss and you are in a position to set your own profit limits. That’s why if you’ve noticed there are numerous businesses here in Kiambu County (SSI#9Male39years).”*

These findings are consistent with those by Speizer *et al* (2005), which found that the burden of family planning is left on the shoulder of the women simply because men are busy running their businesses.

#### **4.2.6 Respondents Average Monthly Income**

The study sought to establish the monthly income of respondents. Establishing this was considered important in the study because it could influence the ability of the respondents ‘in as far as acquiring family planning services and products. In order to establish this, the respondents were asked to indicate their estimated monthly income. Figure 4.3 shows that the majority of the respondents earned between 5000 and 10000 at 52%. This was followed by between 10000 and 20000 at 20%. The minority earned between 20000 and 30000 at 3%. This shows that a majority of the respondents lived way below the poverty line



**Figure 4.3 Respondents Average Monthly Income**

These results therefore shows that a majority of the respondents had low ability to access and acquire some of the non-free family planning services and products such as vasectomy.

*“As a medical officer, I’ve noticed that low income earners are unable to procure non-free family planning services. I’ve heard most of them argue that if the Ministry of Health would make the non-free FP services affordable then they would use them (KII#2MedicalDoctorKiambuHospital).”*

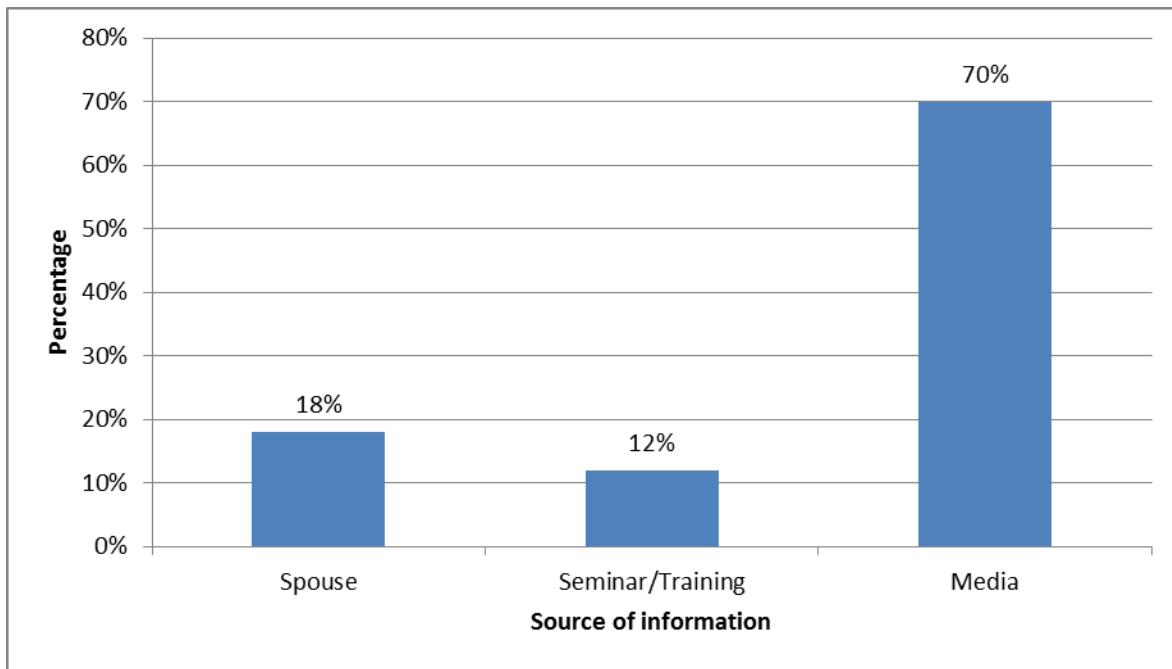
These findings are in line with those of Kamal *et al.* (2013) conducted in Narsingdi municipality in Bangladesh, which indicates that income is associated with male involvement in family planning and reproductive health.

#### **4.2.7 Respondents Source of Information About Family Planning**

The study also sought to establish the source of information about family planning of respondents. The researcher considered this important as source of information could influence the extent to which one is knowledgeable about family planning and whether that knowledge is



satisfactory. To establish this important demographic characteristic, the respondents were asked to mention their source of information about family planning. Figure 4.4 shows that of the 60 respondents, the majority of the responses identified the media as the major source of information forming 70%. This was followed by their spouse at 18%. Training and seminars formed the least responses at 12%.



**Figure 4.4 Respondents Source of Information About Family Planning**

These results indicate that the majority of respondents do not freely enquire about family planning from their spouses thus relying on media which cannot be always satisfactory.

*“I hardly go for training and seminars. It is very difficult for me to discuss matters revolving around family planning and reproductive health with my spouse. As such, I’d rather rely on the media or far much still information from friends (SSI#21Male33years).”*

These findings are consistent with those of Antenane (2002) in Ethiopia which concluded that lack of knowledge about FP in conjunction with lack of spousal communication would inhibit male involvement and adoption of family planning.

### **4.3 Barriers to Male Involvement in Family Planning**

This section sought to present the findings of the study in an effort to establish the extent to which cultural factors and economic factors impede male involvement in family planning.

#### **4.3.1 Cultural Barriers to Male Involvement in Family Planning**

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

##### **4.3.1.1 Gender Roles Challenges on Male Involvement in Family Planning**

The researcher examined the influence of gender roles challenges on male involvement in family planning. To establish this relationship, two questions were presented to the respondents. When asked whether a man should concern himself with issues of family planning these respondents responded as follows.

*“I agree that indeed a man should involve himself with issues of FP since having a family is a collective agreement between a husband and the wife. It really worries me to hear some men so conservative in this issue and leaving it solely to their wives (SSI#1Male42years).”*

*“Male clients are very cooperative if they manage to attend at the family planning clinic, their response is good, they are very attentive and they ask*

*many questions during the visits (KII#1NurseKiambuHospital).”*

*“FP is an issue of women and as such no man should involve himself in such issues. Men should be busy somewhere trying to make a living for their families. Personally, I don’t involve in such matters because I think I’ve got important things to worry about (SSI#2Male31years).”*

Further, the researcher sought to establish the reasons for the response given above. As to this, those who said that a man should never concern himself with the issues of family planning gave reasons including;

*“You will be ridiculed by other people if they ever get to know that you are being involved in family planning. As such you risk the chance of being invited in men meetings of which is very wrong (SSI#3Male51years).”*

In regards to influence of gender roles on male involvement in family planning among the respondents, the study found that even though the community is patriarchal, some men believed that men should concern themselves with family planning. However, the study indicated that even though men should concern themselves with issues of FP, they should not have decisional role in the use of FP but that the choice should be made jointly by both the woman and the man. This shows that FP should be organized to target both men and women to achieve sustainable impact

While those saying that a man should gave reasons including;

*“Family is for both men and women and the involvement of a man is crucial*

*(SSI#4Male34years).”*

*“Male involvement in FP is very important because it will reduce misunderstanding between couples as when one is aware of his partner use of FP methods, will give freedom to women not to hide those methods as some hide pills so as not to be seen by their spouse (KII#2MedicalDoctorKiambuHospital).”*

Providers seeking to promote sexual and reproductive health for men in central Kenya should be sensitive to the fact that if men are not taking full responsibility for their sexual and reproductive behavior, the reason may be that they are acting within a set of cultural norms that determine gender relations. For reproductive health programs to benefit both men and women, they should be based on a better understanding of gender dynamics in the region. The responses on who should make decisions on the use of family planning in the family, the varying responses were as follows;

*“It is equally important for men to concern themselves with the issues of FP just as it is for women (SSI#1Male42years).”*

*“I suggest that a man should hardly have any decisional role in the use of FP. Women should have full role in making decisions on FP (SSI#5Male49years).”*

*“The issue of who should make decisions on the use of FP in the family is supposed to be made jointly by both the man and the woman (KII#1NurseKiambuHospital).”*

The study findings that majority of the respondents are of the opinion that a woman should have full role in making decisions on family planning confirms the fears from the study by Boender *et al.*, (2004), that women’s ability to make sole decision on FP is limited and thus takes away the independence of the woman. Further, the findings explain that even though the respondents felt

that men should have very little decisional role some still felt that men ought to be consulted by women on any decisions regarding family planning. Further, the findings of the study is in line with the finding of the Kenya Demographic and Health Survey 2008-09 in which 16% of men believed that FP is a woman's business and that a man should not have to worry about it (KNBS, 2010). However, these findings conflict with those done in Malawi by Soldan (2004) which concluded that men dominated decision making in family planning decisions.

#### **4.3.1.2 Religious Factors Hindering Male Involvement in Family Planning**

Religion influences human behavior fundamentally. In order to establish the influence religion has on male involvement in family planning initiatives, the researcher asked the respondents whether their religion accepted the practice of family planning. Most of the respondents reported that their religion accepted the practice of family planning while others indicated that their religion was against the practice of FP. Their sampled responses are as follows;

*“I am a Catholic. It's obvious that even the religious leaders in the country are against most, if not all of these family planning methods. My religious teaching indicates that the use of any contraception destroys a couple's potential of giving forth life. Moreover, use of contraception violates the second account of creation which is to multiply the world (SSI#6Male52years).”*

*“I am a Muslim and it is not God's will to implicate effects on our body on our own. According to the religious teachings, use of these methods is like committing murder. My religious leaders are against mobility of these contraceptives since their use is equivalent to murder while I don't advocate for murder. However, as a medic, I suppose the use of FP ought to be a personal choice (KII#4ClinicalOfficerKiambuHospital).”*

*“My church is not against any of these methods. I go to church and at the same time use these methods and I don’t think I am committing any sin whatsoever. I find it a bit barbaric to fulfil the world yet one is unable to provide for his family and no wonder God gave us wisdom to make appropriate decisions such as the use of FP (SSI#8Male38years).”*

The findings of this study are in line with those by Schenker and Rabenou, (1993) and Schenker, (2000) in which they reported that some religions (Catholic and Muslim) considered the act of intercourse must be open to conception and that any contraception destroys any potential to produce new life and thus violates the principal purpose of marriage. These findings further corroborate the findings of a study done by Sileo (2014) in Uganda in which he concluded that mobilization for family planning programs were hindered by the position of some religions.

However, from these findings it is evident that even though religion influences male involvement in family planning, personal choice was a very important factor in determining the ultimate decision on male involvement in family planning being that majority of the respondents accepted that they will go with personal choice principle on this matter.

#### **4.3.1.3 Influence of Spousal Communication on Male Involvement in Family Planning**

The researcher sought to establish this relationship by asking the respondent how often they discussed issues of family planning with their partners and whether such discussion influenced their involvement in family planning. The findings of study indicated that a majority of men discussed the issue of FP with their spouses only occasionally while only a few discussed it regularly while others reported to have never discussed this issue with their partners. Those who

had never discussed FP with their partners mentioned several reasons including fear of being ridiculed, FP being a woman's issue, lack of information of FP, and disapproval of FP.

*“Personally I don't approve the use of family planning in my family. Therefore, I don't see any need to discuss this issue with my partner because it will not change my perception towards FP (SSI#1Male49years);”*

*“This FP thing is a very sensitive issue in the family. When you discuss it with your partner they may think you want to cheat on them. So I prefer not to start such a debate and leave her to decide whether or not she will use any FP method. If she does, then I don't have a problem with that and if not so, I'm quite okay (SSI#9Male47years).”*

*“You see I don't have any relevant information when it comes to FP. I don't know the best method and so even if I talk about it with my spouse I will not know what to say. I therefore opt to hold my peace and just let her be. If I had comprehensive information as such I would have discussed it with her (SSII#2Male53years).”*

Those who ever discussed FP with their partners when asked whether such discussion influenced their opinion towards getting involved responded as follows;

*“Interestingly enough, I in the past did not approve of FP but when my spouse shared this whole issue I was significantly influenced to be more involved. As at now, I regularly discuss the issue of FP with her since I came to realize of its great benefits for the well-being of our family. If she had not shared it with me, I would perhaps be against it up to date (SSI#3Male44years).”*

*“Sometimes men escorted their partners to FP clinics but they stay outside the clinic,*

*and when you ask them inside they don't refuse (KII#3CommunityElder)."*

*"When a male client wants to access FP services from the clinics he might stay outside for long waiting people to clear out as he feels shy to queue with women waiting for service. Most men perceive that FP issues and taking care of children is a duty of women hence men do not show up in clinics neither do they use FP methods. But once they are well supported, I believe this trend will be a different one (KII#4ClinicalOfficerKiambuHospital)."*

*"In order to increase male participation, communities have to be informed about FP especially FP methods to men through campaigns, radio and television in both urban places and in villages (KII#5CommunityElder)."*

These findings prove that spousal communication is an important precursor to the adoption of family planning methods. These findings are consistent with those of Antenane (2002) in Ethiopia that concluded that spousal communication was an important precursor to the adoption of family planning. According to the study couples who discussed family planning regularly were 40% more likely to adopt family planning.

The findings of this study in regards to the influence of spousal communication also corroborate the findings of a study conducted in Nigeria by Oni and McCarthy (1991) which they reported positive correlation between communication and contraception use. Locally, the findings are consistent with those of Lasee and Backer (1997) who analyzed the 1989 Kenya Demographic Health Survey and found statistically positive correlation between husband and wife communication about family planning and contraceptive use, even after controlling for background factors which may have been confounding. In a study conducted by Sileo (2014) in



Uganda he concluded that mobilization of FP programs was majorly done on young couples with a range of 5-10 years length of marriage.

#### **4.3.1.4 Influence of Knowledge of FP on Male Involvement in FP**

The researcher examined the influence of knowledge of FP on male involvement in family planning. To establish this relationship, the respondents were asked, among others, to list the FP methods they know of. The majority identified they had knowledge on implants, pills, male condom and withdrawal methods. However, they did not have information on female condoms, LAM, IUD and male sterilization.

*“Yes I have come across many methods like male condoms, pills, withdrawal methods among others. But things like LAM and IUD have never crossed my mind. About using male condom in the last six months, I would like to state categorically that I cannot put on a condom while making love with my wife. But if its girlfriend, that’s a different thing (SSI#10Male29years).”*

*“I have never heard of any other method in family planning apart from condoms and pills. Those are the commonly used here I guess but I tend to believe majority of men here I included don’t use condoms with their wives (SSI#9Male53years).”*

*“I have never heard of female sterilization. Maybe if it’s similar to tubal ligation, I don’t know (SSI#12Male33years).”*

This shows that knowledge alone may not translate into utilization. This supports a study done in Uganda by Chipeta, Chimwaza and Kalilani-Phiri (2010) in which they demonstrated low use of contraception among populations with high knowledge. Further, these findings are consistent

with more recent findings in Kenya, Ghana in which the researchers found that accurate knowledge on FP is positively associated with increased contraceptive use and intentions (Alvarez *et al.*, 2010; Oketch, Wawire and Mburu, 2011).

These findings corroborate the findings from a study in Bangladesh that showed that male involvement in family planning and reproductive health is higher at 78.8% among men who have high knowledge on contraception, while male involvement in family planning is lower at 39.8% among those who did not have adequate knowledge on contraception (Kamal *et al.*, 2013).

#### **4.3.2 Economic Barriers to Male Involvement in Family Planning**

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

##### **4.3.2.1 Influence of Income Level on Male Involvement in Family Planning**

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

*“Of course I can afford to buy myself a condom anytime I want to have protected sex. Condoms are way much cheaper nowadays with as little as KES 20. But anyone out there who is not in a position to purchase one, they can as well visit Government offices and public health facilities where they are given free of charge (SSI#11Male39years).”*

*“Personally, I am unable to pay for male condoms whenever I want to have protected sex. You see the current economic times have dawned so heavily on us. The KES 20 I*

*would use to purchase a condom I'd rather use it to buy kales for my family. If using a condom is a must, then instead of buying I prefer getting them for free from public health facilities like Kiambu District Hospital (SSI#8Male41years)."*

From the findings of the study, it is evident that a majority of respondents in Kiambu County were able to buy male condoms anytime they wanted to have protected sex while just a small number of them indicated that they were unable to pay for male condoms. This shows that there still exist a number of them who would not be able to use male condoms as a family planning method, even though it is the most preferred most accessible and cheaper form of FP for men.

These findings corroborate those of Kamal *et al.* (2013) conducted in Narsingdi municipality in Bangladesh, which indicates that income is associated with male involvement in family planning and reproductive health. In that study, the researcher found that about 45.4% of males whose income is less than 10,000 taka, 65.3% with an income between 10,000 to 20,000 and 78.7% with an income of more than 20,000 taka per month are involved in family planning and reproductive health Kamal *et al.*, (2013). This study both reveals that male involvement in family planning and reproductive health is proportionally higher among couples with higher income compared with those that had lower income.

The researcher further sought to understand the alternatives available whenever the respondents were unable to buy condoms for use during sexual intercourse. These were their views;

*"In the events where I still consider FP as a crucial element in my family but I am unable to buy a condom, as such I would prefer relying on the FP method of my partner. For me it will be hard to discontinue sex (SSI#13Male33years)."*

*“I don’t like using a condom with my partner but both my partner and I consider FP very important and healthy. So instead of using a condom, I prefer using natural methods such as withdrawal (SSI#10Male47years).”*

*“If I am unable to buy condom anytime I want to have protected sex, since I don’t trust and support female FP methods, I will be better off to discontinue sex until the following day when I can buy myself one (SSI#15Male19years).”*

These findings are consistent with those by Speizer *et al* (2005), that found that if the burden of family planning is left on the shoulder of the women at all times then men only carry a part of that responsibility when they chose to or when it is convenient.

#### **4.3.2.2 Influence of unmet need for Family Planning on Male Involvement in Family Planning**

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

*“I think I am better placed to speak on behalf of other men here in Kiambu County. The only cheap, convenient and reliable family planning method we have access to is male condoms. We are aware of vasectomy but that is equivalent to castration of which none of us will consider it as a family planning method. I believe less than 1% of male population here have access to vasectomy (SSI#7Male55years).”*

This corroborates the findings by Jacobstain and Pile (2007) that access to vasectomy in Sub-Saharan Africa, Kenya included remained at less than 1%.

When asked on what modern method of family planning they desired to use but had no access to, the number of people who desired to use vasectomy but had no access to were the minority while the majority of them desired to use condoms but had no access to them. The number of men with unmet need for both condoms and vasectomy in this study was 49.7% compared to 23% in 1997. The high level of unmet need for men in the study corroborates the findings by Becker S.(1999) who also concluded that the high level of unmet need for family planning in the country greatly affects male involvement in FP and shows that family planning initiatives are not meeting men's demand for family planning (Becker S.1999).

## **CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS**

### **5.1 Introduction**

This chapter presents the summary of findings, conclusion and recommendation of the study.

### **5.2 Summary**

This study set out to; establish the factors that hinder male involvement in family planning in Kiambu County, Central Kenya. The factors were assessed along the lines of cultural and economic. It established that; FP should be organized to target both men and women to achieve sustainable impact, FP choices should be personal, regular spousal communication leads to a positive attitude towards use of FP and reproductive health, the more knowledge a man has on FP, the higher the possibility that he would be involved in the same, inability to buy condoms make men rely on the effectiveness of the FP method used by their partners, and that there is unmet need for FP services targeting men thus the absence of such services hinders their active involvement in FP. In regards to the influence of spousal communication on male involvement in family planning among the respondents, the study found that spousal communication was fundamental in the success of FP especially adoption and continuation.

The study found that a majority of the respondents agreed that discussing family planning with their spouses and partners changed their opinions and made them look at FP positively. Finally, in regards to the influence of knowledge on male involvement in family planning initiatives among the respondents, the study found that the more knowledge a man had on FP, the higher the possibility that he would be involved in the same. On the other objective which sought to assess the extent to which economic factors influenced male involvement in family planning among the respondents, the study found a correlation between economic factors namely income

and unmet needs to influence male involvement in family planning. In regard to influence of income on male involvement in family planning among the respondents, the study also found that income strongly influenced male involvement in family planning. Case Narrative Informants indicated that even though they would want to use condoms every time they wanted to have protected sex, they were unable to afford to buy condoms every such time. The study further found that a majority who are unable to buy the condoms would rely on the effectiveness of the FP method their partners are using. This shows that in a situation where the partner 's method is not effective, then men who would desire to practice family planning will not meet this objective.

In regards to influence of unmet need for family planning on male involvement in family planning, the study found that the unmet need for FP influenced the involvement of men in FP. The study found that vasectomy was highly inaccessible with only small proportion of the respondents indicating that they had access and desired to use such services. Further, the study found that a majority of the respondents had access to condoms while others desired to use condoms but they were unable to access them due to various reasons. These findings show that there is unmet need for FP services targeting men. Therefore, in the absence of these services, men cannot actively be involved in FP.

### **5.3 Conclusion**

This study concludes that; male involvement and participation in FP is still very low in Kiambu County due to unfavorable social and religious climate attributed by lack of full support from society, relatives and religious leaders; men are less informed when it comes to FP and reproductive health; there is a shortage of FP methods/devices targeting men; and that economic constraints among men hinders their active involvement

in FP matters. However, it can be overcome by; developing an effective intervention for boosting male involvement and participation in family planning which would involve partnerships between health providers, religious and community leaders, parents, and media. Moreover, enforcing a community oriented and multi-sectoral approach would have an effect of removing the barriers to male involvement and participation in family planning.

#### **5.4 Recommendations**

The study suggested there be need for:

- i. Implementation of research to ensure that family planning services are widely accepted, cost-effective and achieve high coverage to focus on awareness creation to address the knowledge gaps and demystify the existing myths and perception about family planning.
- ii. Partners and stakeholders who are designing FP programs, projects and activities in the area should ensure to involve men in the entire project cycle to enable them own such initiatives and not see them as ‘outsider’ initiatives. This will ensure that they support such services and have their opinions, contributions and ideas incorporated. Projects that promote adoption of vasectomy however should target men who are 46 and above and not among the younger men who still want to have children.
- iii. The government through the Ministry of Health needs to enhance the reproductive health standards, find a way of training people on debunking the myths especially male



members of the households, and regulation to ensure that family planning services provided are of good quality.

### **5.5 Suggestions for Further Research**

- i. It is recommended that an elaborate study be done covering the whole country and, where possible, disaggregate the population in terms of low income, middle income and high income.
- ii. It will be important for a study to be conducted that compares unmet needs to the contraceptive prevalence rate and total fertility rate in Kenya.

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## APPENDICES

### Appendix I: Written Consent Form

Dear Sir/Madam

#### **RE: REQUEST TO PARTICIPATE IN THE STUDY**

My name is Catherine Kiogora. I am a student at the University of Nairobi currently undertaking a Master's degree in Gender and Development Studies. I have successfully completed my course work for the studies and as part of the university requirements I am carrying out a study on the barriers to male involvement in family planning in Kiambu County. The objectives of my study is to describe cultural and economic factors that impede male involvement in family planning initiatives in Kiambu County and to establish the extent to which cultural and economic factors impede male involvement in family planning initiatives in Kiambu County. You have been purposively selected as an informant in this study by virtue of being a male of reproductive age from Kiambu County. The purpose of this letter is to request your permission to collect data for the research purposes. **All information gathered will be treated with utmost confidentiality and will only be used for academic purposes and in no way will your name or address appear in the report document.** I will appreciate your support and, therefore, look forward to your positive consideration.

**Your participation is entirely voluntary, thus there will not be compensation of any kind** but your experiences could be very helpful to this County and the Country at large towards meeting the national goals of family planning and contraceptive use. The interview takes approximately thirty minutes to complete. Do you agree to be interviewed?



Please sign here as evidence of your informed consent.

Sign\_\_\_\_\_ Date \_\_\_\_\_

Thank you for your cooperation.

## **Appendix II: In-Depth Interview Guide**

### **Section 1: What is your role in Family Planning?**

**Possible probes:** Do you discuss family planning with your partner/ spouse? What are your views concerning family planning in general? How do you feel about your partner/ spouse using family planning? How comfortable are you to use family planning? Is there a particular method you are currently using? Any challenges you have experienced in using it?

### **Section 2: What are some of the barriers that you encounter in assessing and participating in Family Planning?**

**Possible probes:** Have you ever experienced any challenges in accessing family planning services? Do you have any particular challenges in your method of choice? Do you have sufficient knowledge of the available methods of family planning? Do you have any second thoughts towards accessing or using family planning?

### **Section 3: Do you have any recommendations on how these barriers can be overcome?**

(Please Probe if not mentioned)

## **Appendix III: Key Informant Interview Guide**

1. What are some of the roles men play in family planning?
2. Do you feel like men have unmet family planning needs?
3. What challenges and barriers prevent men them from participating in family planning?
4. What recommendations would you give to help national programmes and policies in addressing these barriers?

*Thank You!*



**NATIONAL COMMISSION FOR SCIENCE,  
TECHNOLOGY AND INNOVATION**

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Uhuru Highway  
P.O. Box 30623-00100  
NAIROBI-KENYA

Ref. No. **NACOSTI/P/16/88511/11401**

Date:

**11<sup>th</sup> July, 2016**

Catherine Gatwiri Kiogora  
University of Nairobi  
P.O. Box 30197-00100  
**NAIROBI.**

**RE: RESEARCH AUTHORIZATION**

Following your application for authority to carry out research on "*Barriers to male involvement in family planning in Kiambu County-Central Kenya*," I am pleased to inform you that you have been authorized to undertake research in **Kiambu County** for the period ending **11<sup>th</sup> July, 2017**.

You are advised to report to **the County Commissioner and the County Director of Education, Kiambu County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

  
**BONIFACE WANYAMA**  
**FOR: DIRECTOR-GENERAL/CEO**

Copy to:

The County Commissioner  
Kiambu County.

The County Director of Education  
Kiambu County.

**THIS IS TO CERTIFY THAT:**  
**MS. CATHERINE GATWIRI KIOGORA**  
**of THE UNIVERSITY OF NAIROBI,**  
**39083-623 Nairobi, has been permitted**  
**to conduct research in Kiambu County,**  
**on the topic: BARRIERS TO MALE**  
**INVOLVEMENT IN FAMILY PLANNING IN**  
**KIAMBU COUNTY-CENTRAL KENYA**  
**for the period ending:**  
**11th July, 2017**

**Permit No. : NACOSTI/P/16/88511/11401**  
**Date of Issue : 11th July, 2016**  
**Fee Received : Ksh 1000**



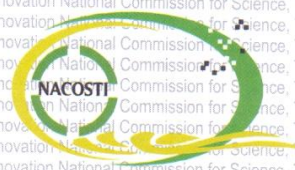
  
**Applicant's**  
**Signature**

  
**Director General**  
**National Commission for Science,**  
**Technology & Innovation**

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



**REPUBLIC OF KENYA**



**National Commission for Science,**  
**Technology and Innovation**

**RESEARCH CLEARANCE**  
**PERMIT**

**Serial No. A 10032**

**CONDITIONS: see back page**