DETERMINANTS OF MALE INVOLVEMENT IN FAMILY PLANNING IN HURUMA WARD, MATHARE CONSTITUENCY

BELDINA MORAA NYAKUNDI

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DECLARATION

This research project is my original work and has not been presented in any other university for examination.

Signature_____ Date: _____

Beldina Moraa Nyakundi

This research project has been submitted with my approval as a university supervisor.

Signature_____ Date: _____

Dr Dalmas Omia

DEDICATION

This research project is dedicated to my dad and mum, Paul and Miriam Araka, brother Dennis and Brian. My Sister, Jacquey and brother in law, John Anthony. You are that glue that held me together when it rained and when the sun refused to shine. You are the best family anyone can ever ask for.

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ABSTRACT

This is a cross-sectional exploratory study of determinants of male involvement in family planning in Huruma Ward, Mathare Constituency. The study investigated the socio-cultural determinants of male involvement in FP as well as the challenges facing male participation in FP. Random sampling sing CDC Epi-Info approach was used to arrive at the sample population. Focused group discussions, Key Informant interviews and survey methods were used for data collection. The study established that socio-cultural determinants of male involvement in FP include religion, cultural perceptions, age and marital status. Challenges identified include covert gender relations, Myths and attitudes towards FP, the traditional role of men in siring children, female influence as well as structural challenges including the dominance of women in FP. This study recommends advocacy and sensitization of men on the importance of their involvement in FP and especially on decision making regarding FP. Further recommendations are also made with regards to use of behavior change communication models targeting men.

LIST OF ABBREVIATION AND ACRONYMS

AIDs	Acquired Immune Deficiency Syndrome
APHRC	African Population Health Research Centre
FGD	Focus Group Discussion
FP	Family Planning
ICPD	International Conference on population and Development
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
KAP	Knowledge, Attitude and Practices
KDHS	Kenya Demographic Health Survey
KII	Key Informant Interview
NACOSTI	National Commission on Science, Technology and Innovation
SPSS	Statistical Packages for Social Sciences
STIs	Sexually Transmitted Infections
UNFPA	United Nation Population Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Family Planning (FP) is a deliberate and conscious decision on the interval (spacing) of children and number (size) of the family. Access and utilization of FP is significant in the light of enhancing maternal and child health with gender relations ramifications. Essentially, by enabling women control birth, postpone and limit pregnancy and supporting reproductive health, family planning reduces maternal and child mortality. Elizabeth and Nancy (2002) note that family planning provides substantial protection against unintended pregnancies that often lead to abortion. Family planning thus reduces the need for abortions, majority of which in sub Saharan Africa are unsafe and often fatal and accountable for maternal deaths. Further, FP helps regulate fertility not only at household level but also on national scale by ensuring appropriate timing and spacing of pregnancy and births; a key demographic factor. "As fertility fall so do infant, child, and maternal mortality" (Vouking, Evina and Tadenfok, 2014; pg. 349). It also increases participation of women in other socio-economic activities as they spend smaller proportions of lifetime giving birth and nurturing of children.

In the context of gender relations and equity, family planning is a central theme. Family planning programs, policies and frameworks have consciously inculcated gender aspect and specifically the involvement of men. At the World Conference on Women in 1995 in Beijing, the neglected area of male involvement in family planning and sexual and reproductive health was highlighted. Similarly, men were cited as key players in responsible parenthood, sexual and reproductive health behaviour including family planning and maternal/child health in the International Conference on population and

Development (ICPD) in 1994. The two conferences emphasized the need for involvement of men in the access and utilization of reproductive health services including family planning. Male involvement encompasses activities that provide family planning and other reproductive health services targeting males as individuals or as part of intimate couple.

The involvement of men in family planning rests on their demonstrated significance in the access and sustained utilization of family planning services. Their involvement is two-fold as in the definition. On one hand, men can use family planning methods such as male condoms to control birth. On the other hand, they can support their intimate partners and peers to use family planning. Research has shown that one important predictor that women will use a contraceptive method is partner support. According to Kabagenyi*et al*. (2014), involvement of men helps in not only in acceptance of a contraceptive method but also in the effective use and protraction. Men can provide the enabling environment, including economic, for contraceptive access and use. For policy makers and gender experts, there has been a concern over male involvement in family planning and regulating family size. Vested with the responsibility of rearing children, men have the obligation thus to plan size of the family, prevent sexually transmitted infections and reap other benefits associated with contraception.

However, despite the illustrated significance of men involvement in family planning, the practice is shrouded with ineffectiveness and against the backdrop of challenges. Traditionally, family planning has been practiced within maternal health setting and has been associated as such within the whole reproductive health package (Kabagenyi*et al.* 2014).

Family planning programs have also focused mostly on women to reduce maternal and infant mortality and excessive childbearing. This has served to perpetuate the perception that family planning is a women's affair and any men's participation is only at the periphery. Resultantly, men involvement in family planning has not been felt profoundly as it should be the case. For instance according to APHRC (2013), men were not allowing and did not wish to use male family planning methods.

Because of decision making position that men hold emanating from the patriarchal societies in Kenya and elsewhere in Africa, it will be of great importance to involve men in FP. Based on the demonstrated importance of men involvement in family planning and the illustrated gap in participation, this study wishes to investigate the determinants of male involvement in family planning. Many studies have looked at family planning with concentration on women and their unmet needs in the context of reproductive health. Other studies have focused more on the up- take of FP in general manner but little attention to the involvement of men and the associated benefits

1.2 Problem Statement

The relevance and role of men in family planning is well demonstrated mainly in decision-making on the spacing of children and family size. Empowerment of women is synonymous with reduction of maternal deaths and high birth rates and as such family planning stands as a human right. Men can use safe and efficient family planning methods and can support their sexually active partners in access and utilization of contraception. However, there is demonstrated gap in the trend and patterns as this involvement is not felt in family planning programs. Traditionally, the programs have focused on women

holistically and within maternal health setting giving little attention to men. Further, in the developing world, research on fertility and contraception has been centred on women and women have been subjects. The studies on men within the context of family planning are few and need to match research emphasis put on women on the same domain.

Knowledge, Attitude and Practices (KAP) surveys on family planning and reproductive health have shown that men are aware and knowledgeable on family planning for meaningful involvement. For instance, KDHS reports have consistently shown considerably high level of knowledge on family planning among men (KDHS, 2008; KDHS, 2014). According to KDHS (2008), 97% of men and 95% of women know at least one contraceptive method. This demonstrated male knowledge of family planning among men's does not match with their active involvement. The study thus sought to investigate the phenomenon and respond to the following research questions.

1. What are the socio-economic determinants of male participation in family planning in Huruma Ward, Mathare Constituency?
2. What challenges are experienced in male involvement in family planning in Huruma Ward, Mathare Constituency?

1.3 Objectives

1.3.1 Overall Objective

To investigate the determinants of male involvement in family planning in Huruma Ward, Mathare Constituency

1.3.2 Specific objectives

To investigate socio-economic determinants of male involvement in family planning in Huruma Ward, Mathare Constituency

1. To identify challenges experienced in male involvement in family planning in Huruma Ward, Mathare Constituency

1.4 Assumptions of the study

1. Gender relations and social/economic capital are key determinants of male involvement in family planning in Huruma Ward, Mathare Constituency.
2. The perception of family planning being a woman's affair and competing financial needs influence involvement of men in family planning in Huruma Ward, Mathare Constituency.
3. There is awareness of family planning methods among the male. This awareness comprise available family planning methods for both men and women

1.5 Justification of the study

Involvement of men in family planning is not just a necessity but also core in achieving universal healthcare. Men involvement has been undermined and much of the attention given to women and maternal health care. Therefore, findings from this research will be useful to interventionists as it will inform policy makers on best practices to increase access and utilization of family planning services. It aims at coming up with best strategies that could be used to increase the male up take and utilization of family planning.

This research also aims at generating information that will be significant in enriching literature on gender dimension on uptake of family planning and the nuances thereof. The

findings from this research can be instrumental to the government in policy reforms and future programming.

1.6 Scope and limitations of the study

The study was conducted in Huruma Ward of Mathare Constituency. It focused on determinants of male involvement in family planning using mixed method. Both qualitative and quantitative methods were used to assess factors influencing male involvement in family planning. The findings are specific to Huruma Ward and are not be generalizable to the entire Mathare Constituency or Nairobi City County. The unit of analysis was individual men and women who are 18 years and above.

1.7 Definition of Key terms

Challenges: Factors/issues that hinder male participation in family planning.

Cultural factors: Established beliefs, values, traditions, laws and languages of a nation or society

Determinants: Factors responsible for male participation on Family planning

Economic factors: factors related to access to family planning services in terms of cost and affordability

Family planning: Use of methods and services of birth control; contraception.

Male involvement: The act of engaging men in reproductive health and family planning; contraception use.

Socio-economic determinants: These are societal and economic related factors that influence meaningful participation of men in family planning.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This section reviews literature on socio-economic factors determining and factors influencing male involvement in family planning. The chapter also reviews the theoretical framework for the study.

2.2 Overview of family planning in Kenya

KDHS (2014) notes that 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). Onyango, Owoko and Oguttu (2010) aver that 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 observed by Sileo (2014) the government is assenting to the global and regional agreements such as the Abuja Declaration, Maputo Protocol, Family Planning 2020 (FP2020) protocol and the ICPD. All these agreements require the government to allocate a given percentage of its annual budgets to the health sector. Amrad (2014) writes that 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. Brown *et al*., (2014) note that 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.

The majority of studies all over the world indicate that women prefer having and running smaller families. According to the UNFPA (2011) as cited in Kiogora (2016), 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 indicates that the people of Kenya will, by 2050, reach about 85 million (APHRC, 2013).

2.3 Male involvement in family planning

Akinso and Akinso (2015) explain that 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 KDHS (2014).

According to Amrad (2014) it is apparent that involvement of men 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, Mganga (2003) adds that 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. 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 (Vouking, Evina and Edoni, 2014). Therefore as observed by WPF (2014), neglecting to provide information and services for men can detract from women's overall health. Men who are educated about sexual health issues are 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)

Ali and Ushijima (2003) find out that 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, Kamal et. al (2013) write that 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. 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 service.

Greene (2000) explains 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 discussions 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 Socio-cultural determinants of male involvement in family planning

2.4.1 Cultural Factors

WHO (2010) describes 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, Oluwasami et al. (2011) add gender inequality determines when to participate and withdraw sex. 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. Wubegzier and Alemayehu (2011) find out that 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 (Sileo, 2014).

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

WPF (2014) adds that in Malawi men determine family size decision-making and the use of contraceptives. However, the study points out those 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. USAID (2011) writes that 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.

According to Ngetich (2013), 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. He finds out that most religions are against the use of modern contraceptive. Similarly Ali and Ushijima (2005) posit that, procreation is the primary purpose of marriages and sexual intercourse for Catholics. As such, the use of contraceptives violates the principal purpose of marriage. They observe that 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. Acayo (2012) adds that 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 Kiogora (2016), religious barriers are quite evident in Africa 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. Kabagenyi (2014) reports that almost all religions in sub-Saharan Africa negative impact on the use of contraceptives makes it hard for conservative males to be involved. In Lurambi constituency, Onyango, Owoko and Oguttu (2010) note 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.

Abdel and Amira (2013) note that 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, as studied by Adelekan, Omoregie and Edoni (2014) 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) describe that over 97% of married women were aware of pills and Depo-Provera methods. They highlight that the number of contraceptives that a couple knows will dictate their use. The same research in Kenya reported that the majority of married men 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. Amrad (2014) 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.

According to Mganga (2003) the extent to which cultural factors impede male involvement in family planning differs based on the social and cultural background of married men. He notes that males have a limited choice of contraceptives due to their personal beliefs, dislike, and perception of contraceptive costs and their side effects. Amrad (2014) describes that cultural factors contribute to higher extent 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 WHO (2010).

Acayo (2013) further explains 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, Ngetich (2013) indicates 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

According to The World Bank (2014), most 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. The World Bank (2010) report indicates that in India, for instance, 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. The research further indicates 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) illustrate 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. Ojakaa (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.

According to the World Population Fund (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, Kamal et.al, (2013) argue that 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 time males are reluctant to adopt. Therefore, consequences that are associated with lack of male involvement in family planning persist in such households World Bank (2014). Further USAID (2011) reports that, in poor countries one in every seven married men have an unmet need for contraception. In sub-Saharan Africa, however, the ratio stands at 1:4 (USAID 2011).

Acayo (2012) found that in Uganda's Lamwo district about 18% were students, 39% were unemployed and 24% were operating small businesses. Employed men in the study accounted for only 16%. He therefore 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 Amrad (2014) adds that 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.

Ojakaa, 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, Ojakaa (2008) concluded that income level among married couples is a crucial determinant of male involvement in family planning.

2.5 Challenges and perceptions on male involvement in family planning.

2.5.1Side effects of female contraceptive methods

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

According to WPF (2014), while women were perceived as having the physical burden of contraceptive side effects, men considered themselves to be indirectly affected by side effects, resulting in requests by several men that their spouses discontinue contraceptive use altogether. Ngetich (2013) explains that men believed that women's reportedly decreased interest in sex due to contraceptive side effects, excessive bleeding was also associated with vaginal odors.

Kiogora (2016) also adds that other perceived side effects which motivated men to oppose women's use of contraception related to concerns in delayed return or permanent loss of fertility, as well as fears that short-term methods, such as birth control pills or injections, could lead to congenital abnormalities.

2.5.2 Dissatisfaction with male contraceptive choices

According to Akinso and Akinso (2015), a second theme related to perceptions that while men were dissatisfied with the perceived side effects of female contraceptives, the two available male contraceptive methods were equally unappealing, namely male condoms and vasectomy, the surgical removal of sperm ducts. Amrad (2014) states that limited access to a more diverse set of male-led methods was cited as additional motivation for men's disapproval of family planning. The permanence and irreversibility of vasectomy was noted, in particular, as inacceptable among men and consistent with losing one's masculinity.

Furthermore as explained by Adelekan, Omoregie and Edoni (2014), given the expansion of modern contraceptive methods designed for women, this raises the possibility of unmet need for family planning among men who in some cases expressed desires to limit child birth due to the financial burden of raising large families. Kiogora (2016) argues that preferences for a male-version of birth control pills were proposed as a potentially convenient male-led method to limit family size. Participants suggested that such short-term technologies for men would increase men's interest in and uptake of family planning services.

Amrad (2014) adds that women echoed similar sentiments relating to the lack of diversity among male contraception methods. There were also views that older men considered male condoms as designed predominantly for unmarried and younger individuals, and thus not well tailored for older sexually active men. Use of male condoms was also associated with distrust among couples.

2.5.3 Perceptions of family planning as a woman's domain

According to Mganga (2003), men and women highlighted gender norms which assigned the role of childbearing and child-rearing to women. Matters relating to fertility and birth planning were also considered to be within this domain. Engaging men in communication regarding family planning was perceived by some as inappropriate and distractive. Given the social expectations for men to earn income for their families, use of men's limited time and mental preoccupation to discuss family planning was considered unduly burdensome.

Furthermore, KDHS (2014) records that men's lack of involvement was blamed on family planning services, including awareness-raising campaigns, which have traditionally targeted women. This was thought to further define family planning as a woman's domain, including initiating partner discussions and managing contraception. Onyango, Owoko and Oguttu (2010) show that in cases where male involvement was perceived appropriate, lack of knowledge about how to be involved was often cited by participants as another deterrent for men.

2.5.4 Family size preferences

The absence of men's support of women's contraceptive use was additionally linked with patrilineal traditions that highly value children and encourage large family sizes. Numerous children were described as a sign of wealth and financial security KDHS (2014).

Akinso and Akinso (2015) add that in some cases, having as many children as possible was believed to be an inherent and religious directive for couples of reproductive age. Conservative points of view challenged the moral legitimacy of family planning and perceived it as undermining the husband's fertility desires. Ngetich (2013) states that promotion of modern contraceptives as a method for birth spacing was also viewed critically by some women who felt such messaging further led to men's negative views regarding participation in family planning.

2.5.5 Fear of partner sexual promiscuity

WHO (2010) explains that in men's view, women's utilization of family planning services may lead them to become unfaithful and reflect women's intentions to avoid pregnancy within extramarital sexual relationships. Men's fears regarding women's perceived sexual promiscuity was additionally linked with stigmatizing beliefs that contraception was most often used in contexts of female commercial sex exchange. Sileo (2014) says that it was not considered acceptable for faithful, married women. Both men and women expressed views that men's anxiety regarding their spouse's potential infidelity was a formidable barrier in defining supportive male roles in the utilization of reproductive health services. Furthermore, USAID (2011) notes men's efforts to defend against other men's sexual interests in their spouse. Family planning methods were described as enhancing women's physical attractiveness by delaying or preventing childbearing, which made men reluctant to support women's contraceptive use. In exceptional cases as written by WFP (2014), women who practiced family planning were also shunned by community members due to perceptions that they were intentionally abandoning the marital relationship

2.6 Theoretical Framework

The study was guided by two frameworks, that is, the theory of social exchange and social cognitive theory.

2.6.1 The Theory of Social Exchange

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 behaviors 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 behavior 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 behaviors. 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 reparative 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 focusing attention to another theory i.e. the Social Cognitive Theory that would discuss how people collectively learn to adapt to behavioral changes.

2.6.2 Social Cognitive Theory

Bandura developed the social cognitive theory in 1986. This theory posits that the process through which people learn to adopt new behaviors 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 behavior 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.

2.7 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 behaviors. 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.

CHAPTER THREE: METHODOLOGY

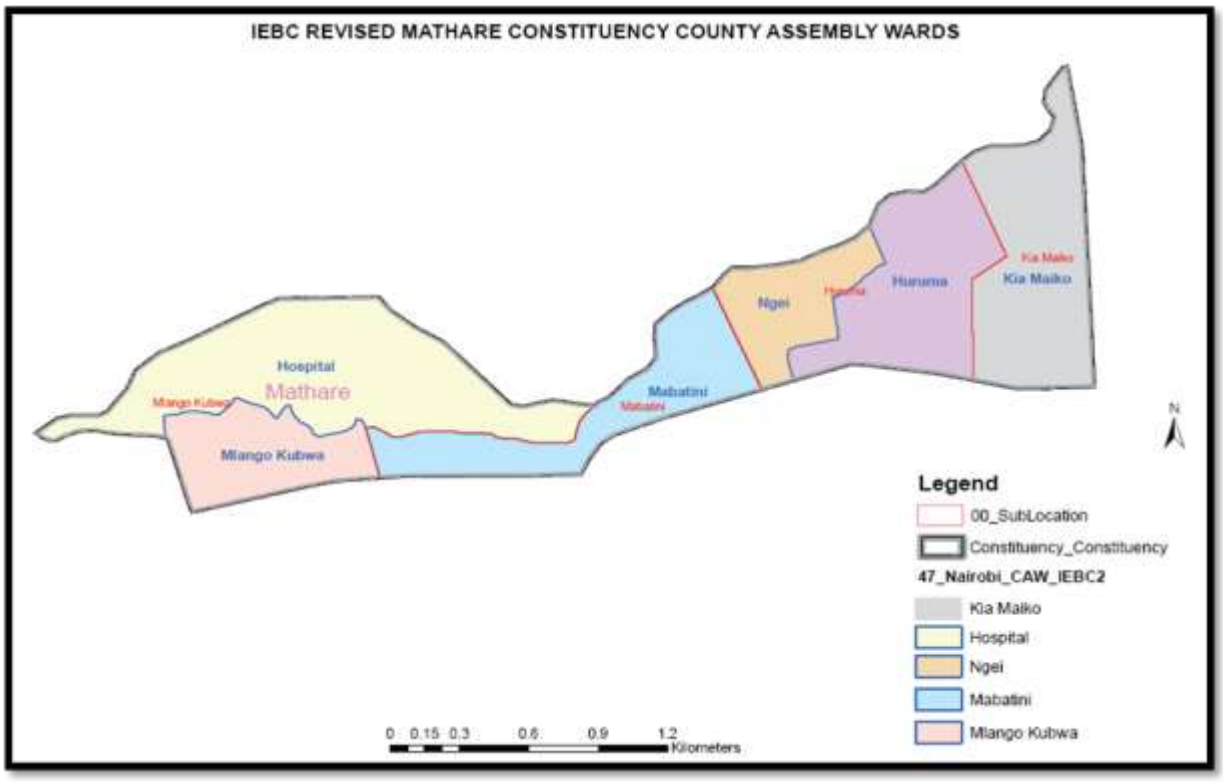
3.1 Introduction

The section on methodology highlights the blueprint or approach that will be used to investigate the determinants of male participation in family planning. The section includes a depiction of the study site, study design, study population and unit of analysis and the sampling population and the sampling procedure. It also includes a description of the data collection methods as well as data processing and analysis. The ethical issues considered are also outlined in this section.

3.2 Research site

The study was conducted in Huruma Ward, Mathare Constituency. Mathare sub-county is one of the sub-counties in Nairobi City County. It is located on the eastern side of Nairobi City County and it is both residential and business region for Nairobi residents. The sub-county has a population of approximately 193,416 persons. Huruma Ward as one of the Wards within Mathare Sub-County covers an area of approximately 0.35 square kilometres (Map 3.1). The Ward has a population of approximately 36,247 persons. Being an informal settlement, it provides a mixed bag in terms of how individuals cope with their sexuality within an urban context. This will also help in teasing out the high level of disparities that exist in a Nairobi City County such as Nairobi with diverse populations and different socio-economic statuses. Huruma Ward has strong prevalence of Luo, Luhya and Kikuyu inhabitants.

Figure 3.1 Map of Mathare Sub-County



Source : www.google.com/search?=mathere+constituency+map&s

3.3 Study design

The study design was cross-sectional and mixed method approach was used. According to Payne (2004), a cross sectional study describes phenomena at one point in time. The study commemnced with an extensive desk review to access all documented data on socio-economic factors and barriers to male involvement in family planning. The study used mixed method approach where both quantitative and qualitative methods were used in collecting data to respond to the study objectives. While the qualitative data yielded subjective data on male involvement in family planning, the quantitative method provided quantifiable data. The study was conducted in two phases. The first phase involved

administering of 100 structured questionnaires to residents of Huruma Ward. The second phase involved obtaining qualitative data through holding focus group discussions with residents of Huruma Ward as well as interviews with key informants.

3.4 Study population and Unit of analysis

The study population comprised men and women living in Huruma Ward Mathare Constituency. The unit of analysis will be the individual man and woman. An inclusion and exclusion criterion were used to select participants in the study. Individual men and women who are sexually active but are below the legal consenting age were not be eligible to participate.

3.5 Sample size and Sampling procedure

The sample population consisted of sexually active men and women whether in marital or cohabitation relationships or not. A set of criteria of inclusion was used to select the sample population. Apart from sexual activity criterion, all participants were aged 18 years and above and were residents of Huruma Ward, Mathare Constituency. The study also targeted women seeking ANC services in public health facilities and men and women who might not want another child.

The study used simple random sampling to select the required sample size. This was based on CDC Epi-Info formular for random sampling of population-based studies. This method gives each unit in the target population an equal chance to be selected for the study.

To arrive at the sample size, the study will apply the formulae:

$$n = \frac{Z^2.P(I-P)}{\frac{e^2}{1+\left\{\frac{Z^2.P(1-P)}{e^2N}\right\}}}$$

Where;

n=is the desired sample size when the target population is greater than 10,000;

Z = confidence level (as a z -score)

P= percentage value (as a decimal)

e= margin of error (as a decimal)

N= population size

$$n = \frac{(1.96)^{2.0.5(I-0.5)}}{\frac{(0.1)^2}{1+\left\{\frac{(1.96)^{2.0.5(1-0.5)}}{(0.1)^{2.17000}}\right\}}}$$

$$\frac{96.04}{1.005149} = 95.5480$$

n=$96\ 96$

n=$\sim 100\ \sim 100$

The sample size is befitting to represent the 17,000 community members in Huruma Ward who are deemed to be 18 years and above. A sample of 100 respondents was randomly selected for the survey questionnaire.

3.6 Data collection methods

3.6.1 Survey

Survey was the main data collection method and aimed at collecting quantitative data. A questionnaire was used as the quantitative tool and had closed ended questions measuring

the likelihood and key barriers in male involvement in family planning. A total of 100 structured interviews were conducted using the questionnaire (Appendix 2). The questionnaire consists of four sections. The first section of the tool is the socio-demographic characteristics where respondents will answer questions about their age, sex, place of residence, religion, level of education and ethnicity. The second section includes respondents' knowledge on family planning. The third section involves the participation of individuals in contraceptive use. The fourth section contains questions on challenges and barriers of participating in family planning.

3.6.2 Focus Group Discussion

This method was used to provide qualitative data on the subjective experiences of men and women using family planning. Based on the sensitive nature of study, the FGDs were disaggregated along gender dimension. Thus, there were men only focus group discussions and women only focus group discussion. Six (6) Focus FGDs were conducted. This involved two (2) FGDs for each category; men, women and youths in the Ward where separate discussions were held to allow for different voices and perspectives to be heard. With permission from respondents, interviews were audio recorded and transcribed verbatim. A focus group discussion guide (Appendix 3) was used to focus on key themes.

3.6.3. Key Informant Interviews

Key informant interviews were conducted to further collect qualitative data. The data was collected through interviewing persons knowledgeable and with deeper experience using family planning. These included men and women (or couple) who have preferably used known methods of family planning for more than ten years. These were selected purposively from the sample population. Additionally, the study targeted healthcare

providers or community health workers who provide family planning services to clients within Huruma Ward, Mathare Sub-county. A key informant guide (Appendix 4) was used to collect data.

3.7 Data Analysis and Presentation

Quantitative data from the questionnaires was sorted, cleaned and checked for completeness. Data were then entered into SPSS computer programme for generation of descriptive statistics. These are presented through charts and tables.

Qualitative data were audio recorded and transcribed. Transcriptions begun soon after a few interviews were recorded and continued throughout the data collection period. The transcripts were checked for accuracy and exported to ATLASti, software for coding and analysis. Coding entailed arranging excerpts thematically through content analysis. Direct quotes were extracted and used to highlight key themes.

3.8 Ethical Considerations

The study sought permit from national authorities for conducting research from the National Commission for Science, Technology and Innovation (NACOSTI) in the Ministry of Education, Science and Technology.

The researcher issued and read the informed consent forms (Appendix 1) to the participants which they for their confirmation and subsequent signing. In the informed consent, the researcher explained the purpose of the study and the process that will be used. The participants were made to understand that their participation in the study was voluntary and that they were free to withdraw at any stage and without suffering disfavor. The researcher guaranteed the participants confidentiality and anonymity. Towards this end, the researcher

assured the participants that the information they gave were to be held confidential and were not to be used for other purposes than the stated one. All interviews were conducted at private spaces meeting the comfort and convenience of the participants. Research materials were safeguarded and all systems used were password protected.

In anonymity, the participants were not identified by names and their identity was not linked to the information they gave. Thus, no names were used and any potential identifier were removed and replaced with a pseudonym while the rest remained true to data.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This section presents the findings of the study and makes inferences from the trends observed. The findings are presented in tables and figures. Each section respondents to the study objectives.

4.2 Demographic characteristics of the respondents

Most of the respondents were aged between 18 and 35 years at 47%, those between 36-53 years old stood at 33% while those above 54 years were 19%. Female respondents were 53% while male respondents comprised 47% of the total number of respondents. Respondents who indicated that they were single were married were 69% while those who were single were 12% of the total population of the respondents. About 36% of the respondents had complete primary education, 25%, had complete secondary education and 20% had college/university education. Proportion of respondents with monthly earnings of Kshs.4, 000-6,000 were 37% while those with Kshs. 3,000 or less monthly income were 24%. The demographic characteristics are summarized in table 4.1 below

Table 4.1: Demographic characteristics of the respondents

	Variable	Frequency	Percentage
Age	18-35 years	47	48
	36-53 years	32	33
	54 years and above	18	19
Gender	Male	46	47
	Female	51	53
Marital status	Single	12	12
	Married	67	69
	Divorced/separated	18	19
Educational level	Primary complete	35	36
	Secondary incomplete	24	25
	Secondary complete	18	19
	College/University	19	20
Income level	0-3 000	23	24
	4000-6000	36	37
	7000-9000	28	29
	10000 and above	10	10

4.3 Male participation in FP

The study sought to understand the levels of male participation on FP. The results show that about 50% of both male and female respondents indicated that men did not participate in FP at all. About 51% of female and 49% of male respondents indicated that men did not participate at all. Those who indicated that men participate always were 14.5% (12% for male and 17% for female). Figure 4.1 presents the findings.

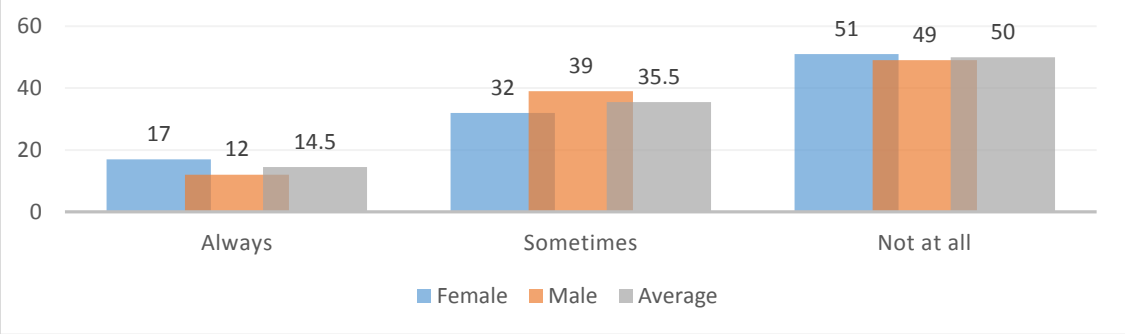


Figure 4.1. Levels of male participation in FP

4.4 Socio-cultural determinants of male participation in FP

4.4.1 Religion

While Christianity was the dominant religion in the study area, the study revealed that religious affiliations influenced male participation in FP (p=0.001). Most Muslims (77.2%) and Christian Catholics (55.3%) did not participate in FP. On the other hand, most Christian protestants (41.1%) and persons professing no religion (44%) participated in FP sometimes. The findings are as presented in Table 4.2

Table 4.2: Religion

	Always	Sometimes	Not at all	X^2	P-Value
Christian Catholic	6.4	38.3	55.3	61.23881	0.001
Christian Protestant	22.6	41.1	36.3		
Muslim	4.2	18.6	77.2		
No religion	24.9	44	31.1		

From the Focused group discussions and Key informant interviews, it emerged that use of contraception is perceived to be against religious dictates. It thus follows that social isolation and rejection by friends and neighbors if one's actions become known to others is eminent. Christianity was noted as the dominant religion in Siaya county, Islam in Mombasa and both Christianity and Islam in Nairobi. It emerged that both beliefs influenced uptake of FP methods. Participants categorically indicated that withdrawal method is discouraged by the Bible. This is based on the Biblical story of a bible character called Onan (recorded in Genesis 38:8-10) who was cursed for practicing withdrawal. A participant indicated that

> "the withdrawal method has been condemned biblically. This is recorded in the Bible….it is a Sin. If people know that one is doing that it always brings shame. So they do it secretly" (Female FGD, 35-49)

Participants in the FGD also indicated that Christianity and especially non Catholics discouraged use of FP.

> "Catholic supports family planning but we have these sub churches I do not know how they are called, I do not know how I can categorize them…they discourage their members from participating in it…to them, it is a big sin that must be discouraged" (Male FGD, 25-34 Years)

It also emerged that among the Muslims, FP was considered profane although the teachings of Islam do not forbid contraception. The reasons given was that FP limited the number of children one could have against the backdrop of a desire for many children in the Muslim culture (Kambigwu 2000). A participants indicated that,

> "There are our fellows like Somalis. I think that because of religion. Our Muslim friend many women don't plan because denomination doesn't allow. Also Catholics, their denomination doesn't allow. But our Somali friends don't plan totally. If the wife is secretly using then the husband realizes, it will give the husband the advantage of marrying up to the fourth wife (Female FGD, 35-49 years).

4.4.2 Cultural Perceptions

Cultural perceptions were investigated by use of a 5-point Likert type questions where SD= Strongly Disagree, D=Disagree, N=Neutral, A=Agree and SA=Strongly Agree. Mean values are used to indicate the direction of the responses. Table 4.4 below represents the findings.

Table 4.3: cultural perceptions regarding male participation in FP

	SD (%)	D (%)	N (%)	A (%)	SA (%)	Mean
My culture does not allow men to use contraceptives	2.2	6.7	4.4	62.2	24.4	4.001
Men who use contraceptives are going against the culture	11.1	4.4	11.1	68.9	4.4	3.51
When men are involved in FP, they are perceived as weak	6.7	15.6	11.1	46.7	20	3.578
There are cultural consequences when men participate in FP	13.3	6.7	26.7	22.2	31.1	3.511
My culture allows men to participate in FP	42.2	22.2	6.7	20	8.9	2.312

From Table 4.4 above, most participants agreed with the statement that culture does not allow men to use contraceptives (M=4.001), that when men are involved in FP, they are perceived to be weak (M=3.578), that men who use contraceptives are perceived to be weak (M=3.51) and that there are cultural consequences of male participation in FP (M= 3.511). However, most participants disagreed with the opinion that culture allows men to participate in FP (M= 2.312)

4.4.3 Age

Participants aged 18-35 were the majority and were also associated with participation in FP (28.2%, p=0.0023). Participation in FP decreased with age. Those aged 54 years and above recorded least participation (7.2%). Table 4.5 below presents the findings.

Table 4.4: Age and participation in FP

Variable	Always	Sometimes	Not at all	X^2	P-Value
18-35 years	28.2	45.8	26	48.42215	0.0023
36-53 years	8.2	38.8	53		
54 years and above	7.2	21.8	71		

From the Key informant interviews and the focus group discussions, it emerged that male participation in FP was mostly associated with young people. Most participants indicated that young people have the time to participate in FP and that they are also not much in reality with existing cultures. One of the informants indicated that,

> Young people mostly….some of them do not care about the cultures. They also have a lot of time hanging around with their wives and this is different from what we have observed over time (KII, Male, 38 years).

4.4.4 Marital status

As indicated in Table 4.6, marital status determined male participation in FP (0.003). Participation in FP was mostly common among those cohabiting (20.6%). Least participation was recorded among the married (6.4%). Table 4.6 below presents the findings.

Table 4.5: Marital status and participation in FP

	Always	Sometimes	Not at all	X^2	P-Value
Single	16.2	29.6	54.2	16.242	0.013
Married	6.4	34.2	59.4		
Divorced/separated	14.8	34.8	50.4		
Cohabiting	20.6	43.5	35.9		

Findings from the Key Informant Interviews and the Focus Group Discussions indicated a trend of male participation mostly in cases where an individual was perceived to be in marital arrangements which does not require siring of children. Those cohabiting or are in marital arrangements referred to as “not serious” (To mean single) in most of the FGDs and KII were motivated by their desire not have children to participate in FP. One of the participants in an FGD indicated that.

> Marital status is mostly in the cases where an individual is not serous with the relationship and therefore does not want children…you know children would tie them to be married….so they take their wives to clinics where they are advised on the type of FP to use. They are motivated because of this (Male FGD, 25-34 Years)

4.4.5 Levels of education

The study also investigated levels of education as a determinant of male participation in FP. Table 4.7 presents the findings

Table 4.6: Level of education as a determinant of male participation in FP

	Always	Sometimes	Not at all	X^2	P-Value
Primary complete	13.2	36.7	50.1	1.572712	0.954519
Secondary incomplete	12.6	33.4	54		
Secondary complete	15.2	36.2	48.6		
College/University	17.1	35.8	47.1		

The findings as indicated in Table 4.7 indicates that levels of education is not a determinant of male participation in FP (p=0.954519). The respondents were also asked to indicate their levels of agreement with the statement that levels of education influence male participation in FP. Figure 4.2 presents the findings.

The findings indicate that most of the respondents did not perceive levels of education as a determinant of male participation in FP (Neutral, 36.4%, Strongly Disagree, 22.8% and Disagree, 19%)

4.4.6 Levels of Income

The findings of the study indicate that levels of income does not determine male participation in FP (p=0.62902). Table 4.8 presents a summary of the findings.

Table 4.7: Levels of income as a determinant of male participation in FP

	Always	Sometimes	Not at all	X^2	P-Value
0-3 000	13.8	28.4	57.8	4.353009	0.62902
4000-6000	14.2	35.4	50.4		
7000-9000	13.8	38.2	48		
10000 and above	15.8	40	44.2		

About 44.2% of high-income earners (10,000 and above) did not participate in FP. This was also true of lowest income earners (57.8%). About 15.8% of those who earned 10000 and above also participated in FP. Finings from the Focus Group Discussion and Key Informant Interviews also revealed that levels of income did not determine participation in FP. A female informant indicated that.

> One's level of income does not determine their participation in FP. In anything, the poor and the rich are also religious and cultural. Would I would say in that it depends with the levels of exposure one has. Those who are less exposed would oppose FP and would not even participate in in. But if you understand and you are well informed, then it is good to always discuss contraceptive use with your spouse (KII, Female, 35 years)

4.5 Challenges facing male participation in FP

4.5.1 Gender relations: covert use of FP

Many women held the view that FP methods were most relevant to women than men. Participants pointed out that women are the ones who take care of children and are the ones blamed when unwanted number of children is achieved. As a result some women used FP methods without their husbands' consent. This was done deliberately to protect their health and the plight of their children. One male participant said:

> "As a man of the house, there can come a time when you feel we should get another child, so you keep trying yet your wife has hidden the truth from you. Then one day she tells you that she uses FP, you will become a bit wild because she has denied you what you want then she will say that you have to wait a little longer, that will result into conflict" (Male FGD, **25-34)**

In other instances, Community Health Volunteers targeted women for awareness creation. This was seen as inadequate as men would still sire children with other women.

> "There are shortcomings because if they would have been targeting men also, if they want to reduce population, if the man is not targeted about family planning, he will go and have family elsewhere. In his house with his wife, they are going for family planning, but he can impregnate another woman outside. So population remains the same. But if they go for family planning then it would be easy to control the population". (Female FGD, 35-49 years)

With the notion that FP was a woman's affair, it emerged that men found reasons not to accompany their wives to clinics for FP sessions with the providers. Most men claimed to be committed elsewhere and that their participation was not necessary. One woman said:

> "the difficulty for men to take their women to the hospitals is brought about by their excuse that they are busy. Even there are times that the doctors tell you to go with your husbands to the clinic for medical check-up but they don't want. They ask themselves what they are going to do in the hospital and say that it's the woman's work. They forget that they were also involved in looking for this child" (**Female FGD, 35-49 years**)

In other instances, participants were of the view that, traditionally, men were the heads of households and decision-makers in all issues in their respective households. Men decide on FP and the number of children. Since men were the decision-makers, they were expected to initiate discussions on FP and the number of the children the couple want to have. Women were not considered decision-makers, but implementers of what had been decided by men, without questioning men's decisions. As one female commented:

> "Sometimes maybe you have one child, and she's on FP, I will take it as she despises me. She doesn't want to have children with me that will be the decision. So there has to be some quarrel in the house" (Male FGD, 25-34 years)

4.5.2 Myths about contraceptives

Among the respondents, fear and concerns about family planning were a major barrier to use. Many of their fears were based on myths and misconceptions. The largest concern cited by participants was fear that a particular method would require participation of their husbands. In many cases, this prevented them from using contraception.

> ." So I have tried pills, g-dale and injections but I have not tried coil although I fear it because they say the size of the penis of your husband must be known for it to be inserted but I don't want my husband to know I use it. So if it's something that someone can go secretly I will go for it and when I am with my husband and he can find out then it can be an issue and this is why I am very cautious" (Female DGD, 18-24 years)

4.5.3 The role of others in influencing contraceptive use

It emerged from the discussions that in-laws played an important role in use of FP. Young women were expected to have children once married. These women are directly prevailed upon to have children and disregard use of FP

> "The pressure can also come from both sides of the family, the parents of the man may see, maybe the boy has brought a girl home and maybe they see this girl does not get pregnant ignorance can still come out of that story because you can get this girl is not getting pregnant so the parents and friends are asking why this girl is not getting pregnant, not knowing that maybe this man is the one with a problem. I don't know how I can put it but people should know their fertility status such that it can help a lot of things like HIV status, because maybe I will say my wife is not getting pregnant let me look for it in another place and in the process I might get sick, so it is a broader picture.

In other instances, it emerged that physical violence would be meted on the woman if she fails to have children. It was thus the role of the woman to ensure that she gives birth to children uninterrupted. One woman noted that;

> " … there is this woman whose hands were cut because she was not giving birth and they had stayed and he saw this woman is not giving birth, so this things happen with both sides, the woman can also give the man pressure, the man can also give the woman pressure, so that is something that happens with both parties" (Male FGD, 25-34)

4.5.4 Traditional role of men in siring children

Male FP methods such as condom use and vasectomy were also available among the study participants. However, vasectomy was dreaded since it rendered men incapable of siring more children against their traditionally prescribed roles in reproduction. The participants indicated that a man becomes disadvantaged when he goes for vasectomy. One participant indicated that;

> "I'll add a little bit. Especially that for vasectomy. As we said in the beginning, men don't give birth, they impregnate. So it might reach to a point where the wife can no longer give birth. So if this man gets another woman he will not be able to sire children. So it will be a big shame to the husband if he can't sire children. The second one is us women who are mouthy. We can't keep a secret. 'My husband always withdraws' and these words may go round until it reaches the husband. We should keep secrets as women" (Female FGD, 35-49 years)

It also emerged that fewer FP options are available for men as compared to women who had a variety of FP method. This was perceived to be greatly disadvantaging men when it comes to FP. In a male FGD, a participant observed that;

> "So when he goes for vasectomy, he will see that he is disadvantaged. So he sees that the woman is the one who should go for family planning. And men don't have many options like women. There are more options for ladies than men. Men just have male condom and maybe vasectomy" (Male FGD, 35-49 years)

4.5.5 Structural challenges

Respondents indicated that there were stigma associated with male participation in FP (78%), that men lack time out of their daily roles/routines to participate in FP (76%) that there were inadequate FP options for men (56%) and that FP messages did not target men (42%). Figure 4.3 presents the findings

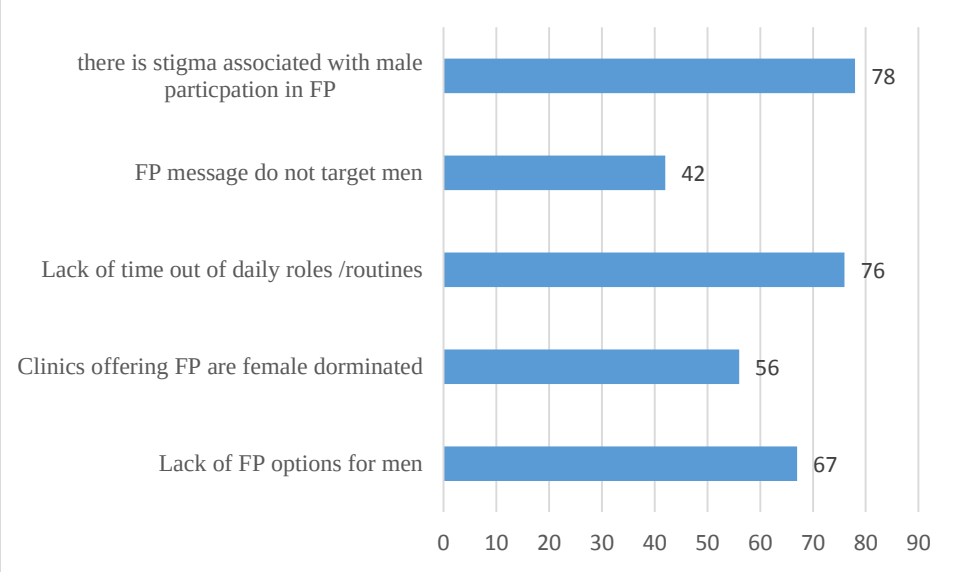


Figure 4.2: Structural challenges facing male participation in FP

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

Male participation in family planning plays an important role with regards to decision making for high uptake of family planning services. This, inturn leads to better maternal and child health In this study, male involvement in FP was low. About 14.5% of the sampled respondents indicated that male partners were always involved in FP, 35.5% sometimes and 50% not at all. Factors socio-cultural factors identified as determining male participation include religion, cultural perceptions, age and marital status ($p<0.05$). levels of education and income were not determinates of male participation in FP.

While there was low male involvement in FP in the study area, those professing Islamic and Christian catholic religious beliefs had lowest levels of participation as compared to their counterparts professing both Christian protestant and those with no religion. This finding leads to an understanding that religious beliefs determines male participation in FP. In a study conducted by Ngetich (2013), 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. He finds out that most religions are against the use of modern contraceptive. Similarly, Ali and Ushijima (2005) posit that, procreation is the primary purpose of marriages and sexual intercourse for Catholics. As such, the use of contraceptives violates the principal purpose of marriage. This study thus concurs with those of Ngetich (2013) and Ali and Ushijima (2005)

The study revealed that cultural perception was a strong influence of male participation in FP. There were perceived cultural consequences of male participation in FP. Generally, respondents had cultural perceptions which they believed were strong barriers to their participation in FP. Decisions to be involved in FP is thus influenced by the belief that

culture delineated roles including those of maternal reproductive health to women as opposed to men. This finding leads to a conclusion that cultural perceptions determined male participation in FP. While it was beyond the scope of the current study to investigate the specific cultural norms regarding FP, the findings of this study mirrors those of Oluwasami et al. (2011) who reasoned that gender inequality determines when to participate and withdraw sex. The scholars further provided that cultural hurdles, which vary from one culture to the other, and are common to all cultures in the world, lead to men shying away from reproductive health issues. Wubegzier and Alemayehu (2011) find out that in a patriarchy society, gender inequality would result into men downplaying FP as women's affair.

On age, the study established that age determines male involvement in FP. Younger people tended to associate themselves with their reproductive health. Many factors could be attributed to this including the fact that they are perceived to be sexually active and therefore likely to use contraceptives for birth control. In a study conducted by Kamal et.al, (2013), younger people were found to be more knowledgeable on contraceptive use as compared to the elderly. It is thus possible to infer that knowledge could translate to use in the case of the current study. Going by that reasoning, this study thus finds younger people more involved in FP as compared to the elderly. It is thus concluded that age is a determinant of male participation in FP and that younger people are more likely to participate in FP as compared to the elderly.

Finally, marital status was a determinant of male involvement in FP. Least participation was recorded among the married while those cohabiting had the highest levels of participation. This finding leads to an understanding that marital status determines male

involvement in FP. In a study conducted by Abdel and Amira (2013), single individuals who were sexually active had vast knowledge on FP as compared to married people. The scholars attributed this to a possibility of having open discussions with their partners regarding FP. It is from such arguments that the scholars present marital status as a determinant of male involvement in FP. The current study finds high levels of male involvement in FP among cohabiting, single and divorced individuals. This finding concurs with the findings of Ali and Ushijima (2005) who posited that procreation is the primary purpose of marriages and sexual intercourse for Catholics. It could thus be reasoned that male participation in FP among the married couples is overshadowed by the need for procreation.

Challenges affecting male participation in FP include gender relations and the covert use of FP. Under this theme, the study revealed that common perception regarding FP is that women take care of children and thus it is their prime role to plan their families. That role thus presupposes women to make decisions regarding FP at the right time and not involve their husbands. This challenge presents a hindrance for decision making since all decisions are to be approved by the man. In a study conducted by Mehta *et al*.(2002), decisions made by women regarding FP were met with violence when in the first place, men shied from participating in such decisions. The double standard position with regards to decision making thus presents a challenge in FP uptake.

The study also established existence of various myths and misconceptions regarding FP use as a challenge to male participation in FP. Such myths and misconceptions present fears which could easily result into blame games among the couples. It is for this reason that men sometimes do not want to be involved in FP. Closely associated with this

challenge is the role played by others in influencing FP use. The study revealed that in-laws played an important role in determining FP use. Such challenges thus makes it difficult for men to participate in FP issues within their marital relations.

CHAPTER SIX: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary

This study explored determinants of male involvement in FP in Huruma Ward, mathare constituency, Nairobi County. The study specifically looked into socio-cultural determinant of male participation as well as challenges facing male participation in FP. The study established that socio-cultural determinants of male involvement in FP include religion, cultural perceptions, age and marital status. The study also established that challenges facing male participation in FP include covert gender relations, Myths and attitudes towards FP, the traditional role of men in siring children, female influence as well as structural challenges including the dominance of women in FP. The study also established that levels of educational and income did not determine male participation in FP.

6.2 Conclusions

From the study findings therefore, it is possible to concluded that there is generally poor low involvement of men in FP. Family planning issues are generally left for women. It is also possible to conclude that socio-cultural factors determine male participation in FP. Most men who participate in FP are either protestant Christians or those with no religion. Similarly, men who are single or are cohabiting are more likely to participate in FP. Further, participation of men in FP is determined by various cultural perceptions which seem to prohibit male participation in FP issues. Finally, men of younger ages seemed to embrace FP more as compared to the elderly.

On challenges, the study concludes that various factors act as hindrances to male participation in FP. Such include structural factors, the traditional role of men, various myths and misconceptions about FP as well as gender relations in the society.

6.3 Recommendations

- Given the important role played by men in decision making, more advocacy and sensitization targeting men should be conducted by the ministry of health through the community health volunteers.
- There should be more behavior change communication strategies in the study area. Such strategies should consider bests channels to reach men including use of media in various platforms.
- The government through Ministry of health and in collaboration with other development partners should consider organizing seminars for male champions which in turn could be used to advocate for male participation in FP.
- Future studies should consider specific cultural issues men consider to be barriers towards their participation in FP.

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APPENDICES

Appendix I: Consent form

Investigator: Beldina Moraa Nyakundi

Introduction

I am Beldina Moraa Nyakundi from the Institute of Anthropology, Gender and African Studies, University of Nairobi. I am conducting a study on**: Determinants of male involvement in family planning in Huruma Ward, Mathare Constituency**

Purpose

The study seeks to explore determinants of male involvement in family planning in Huruma Ward, Nairobi County.

Procedure

If you agree to participate in the study, you will be asked various questions related to the study. Although you will be asked certain specific questions, you will be free to provide more information that is relevant to the themes being addressed.

Risks/Discomfort

There are no risks in participating in this study.

Benefits

Although there will be no direct or immediate benefit for participating in the study, the investigator will assist in answering questions that you may have. Further, the study aims at exploring the socio-economic factors relating to male involvement in family planning. The findings might inform policy and programmes for improve uptake and general support of FP.

Confidentiality and Anonymity

Your confidentiality will be maintained at all times during the study. The information provided will not be used for any other purpose than the one stated. The names or identifiers of participants will not be used in the report or publications which may arise from the study. True identification of participants will be concealed at all times.

Compensation

There will be no direct compensation for your participation in the study although you will be reimbursed your transport expenses.

Voluntariness

Participation in the study is voluntary. You will be free to withdraw at any stage of the study and doing so will not attract any penalties or discrimination whatsoever. However, I humbly request for your cooperation, which will be highly appreciated.

Persons to contact

If you have any questions regarding the study, you can contact Beldina Moraa Nyakundi through telephone number 0724654482 or email through betinamoraa@gmail.com.

I would like to know whether you have a question to ask now. If no, would you like to participate in the study? If yes, please sign the space below.

I_____ hereby voluntarily consent to participate in the study. I acknowledge that a thorough explanation of the nature of the study has been given to me by Mr./Ms._____. I clearly understand that my participation is voluntary.

Signature_____Date_____

___

Signature of Reseacher/Assistant_____Date_____

Appendix II: Questionnaire for community members

INTRODUCTORY AND SCREENING REMARKS

I am Beldina Moraa, an MA Student in Gender and Development Studies at University of Nairobi. I am carrying out a research on determinants of male involvement in family planning in Huruma Ward, Mathare Sub-county. With your permission, I would like to ask you some questions about your views on some issues around family planning and its practice around here. I would therefore want to find out the level of knowledge and awareness on family planning, methods of family planning known and used, the level of participation and the role played and the challenges experienced in accessing and participating in family planning in this ward. Your insights and experiences will be important in finding solutions to address the problem. The interview will last for a maximum of 30 minutes.

Your participation is voluntary and you may therefore refuse to answer any questions or stop the interview at any time without suffering any consequences. You will receive no direct benefits from your participation in this study; if you choose to participate you will be helping me to understand the nature of the problem and try to improve male involvement in family planning in Huruma Ward. All the information given in this study will be kept in the strict confidence. Your name will at no time be associated with the information you are giving. Please answer honestly where choices are given and tick the options which match your answers. Otherwise, write out the information asked for in the blank space after the question.

May I continue **YES** **NO**

If NO, thank them for their time and move on.

If YES, thank them and proceed to completing the questions.

SECTION ONE: SOCIO-DEMOGRAPHIC CHARACTERISTICS

Name of respondent (Optional) _____

How old are you?

[ ] 18-34 [ ] 36- 53 [ ] 54 and above

Please record respondent sex

[ ] Male [ ] Female

What is your marital status?

[ ] Married

[ ] Single

[ ] Divorced

[ ] Widowed

[ ] Other_____

What is your place of residence?

Kindly indicate the sub-location of your residence in the ward

[ ] Huruma [ ] Other

How long have you been a residence of Huruma Ward?

[ ] Less than 5 years [ ] 6-10 years [ ] 11 years and above

What is your religion?

Muslim [ ] Catholic [ ] Protestant [ ] African traditional religion [ ]

No religion [ ] Other [**]**

What is your highest level of education?

No school [ ]

Primary: [ ] completed [ ] incomplete

Secondary: [ ] completed [ ] incomplete

College/University: [ ] completed [ ] incomplete

What is your main occupation?

_____

What is your ethnicity?

Luhya [ ] Luo [ ] Kisii [ ] Kikuyu [ ]

Kamba [ ] Somali [ ] Other_____

SECTION TWO: KNOWLEDGE OF FAMILY PLANNING

1.1 Do you know family planning is or hard about family planning?

Yes [ ] No [ ]

1.2 What methods of family planning do know?

Specify_____

_____

1.3. What is the source of information on FP?

[ ] Spouse [ ] Family [ ] Friend [ ] Neighbor

[ ] Media [ ] Other _____

.

1.4. Do you know any male methods of family planning?

[ ] Yes [ ] No

If Yes, specify _____

If No, skip to the next question.

1.5 Are you aware of programme(s) that support male contraceptive use?

[ ] Yes [ ] No- go to 1.7

1.6 If yes, kindly specify

_____

1.7 In your view, what is the general awareness of FP by the members in this ward?

[ ] Very high

[ ] High

[ ] Low

[ ] Very Low

SECTION THREE: PARTICIPATION

2.1 Are there avenues in the community where men and women come together to talk about family planning methods?

[ ] Yes- briefly explain.....

[ ] No – go to 2.4

2.2 Who are involved in these meeting and running of the prigrammes? (tick all that apply)

[ ] Women groups

[ ] Men groups

[ ] Community leaders

[ ] Don't know

2.3 Have you participated in or supported family planning?

[ ] Yes [ ] No

2.4 If yes, what methods have you used?

_____

_____

2.5 Do you know of any man or men who are using and supporting?

[ ] Yes- please specify the type of support or methods

_____

[ ] No

2.6 How are contraceptives such male condoms provided to the community?

[ ] Ward office [ ] Local Clinics [ ] CHV/W

[ ] MCA's office [ ] [ ] Don't know

SECTION FOUR: CHALLENGES

3.1 Do community members have problems in accessing FP methods and services in this ward?

[ ] Yes [ ] No

3.2 If yes, what are the problems like?

_____
_____
_____

3.3 What are causes of these challenges?

_____
_____

3.4 What problems do men experience in using FP?

_____

3.5 How do men overcome these challenges?

_____

3.6 What are the most preferred FP methods by men?

_____

3.7 Why the preference of the above method(s)

_____

3.8 Any questions regarding what we have discussed?

We have now reached the end of our interview. I would like to thank you for taking the time to talk to me. Thank you so much.

END

Appendix III: Focus Group Discussion (FGD) guide

BIO DATA

Age:

Gender:

Ethnicity:

Marital Status:

Education:

Occupation:

1. Knowledge on family planning.
2. Types of family planning methods used and the challenges.
3. Roles played on family planning use and choice.
4. Barriers encountered in accessing and participating in Family Planning.
5. Recommendations on how the barriers and challenges can be overcome.
6. Efficiency of service provision.

Thank you for participating

Appendix IV: Key Informant Interview (KII) guide

BIO DATA

Name:

Sex:

Age:

Organization:

Position:

Years of service:

Years of service provision on FP and the trends over time.

Types of family planning methods promoted and the targeted population

The roles men play in family planning.

Challenges and barriers that prevent men from participating in family planning.

Relationships between service providers and the targeted groups.

Existing policies on FP and the gaps.

Recommendations to help national programmes and policies in addressing these barriers.

Thank you for participating

Appendix V: Research Budget

ITEMS	QUANTITY	UNIT PRICE	TOTAL COST
Study Tools(guides, consent forms)			1,000
Research Permits (NACOSTI)	1	2,000	2,000
Note Books	15	200	3000
Research Assistants	1	10,000	10,000
Refreshments for FGDs	50 pax.	200	10,000
Total			**26,000**

Appendix VI: Work Plan

Activities	June.	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.
Proposal writing and literature review									
Proposal defence and corrections									
Data collection									
Data processing and analysis									
Paper submission									
Paper Publication									