

**THE ROLE OF MEN IN FAMILY PLANNING: AN EXPLORATION OF  
PERCEPTIONS OF MEN TOWARDS CONTRACEPTIVE USE BY WOMEN IN  
MARIGAT LOCATION, KENYA**

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**A mini-thesis submitted in partial fulfillment of the requirements for  
the degree of Masters in Public Health (MPH) in the School of Public Health,  
University of the Western Cape**



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**2008**

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**KEYWORDS**

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Family planning

Reproductive age

Contraceptives

Focus Groups Discussions

Qualitative research

Men

Women

Perceptions

Knowledge

Attitudes



2008

## ABSTRACT

### THE ROLE OF MEN IN FAMILY PLANNING: AN EXPLORATION OF PERCEPTIONS OF MEN TOWARDS CONTRACEPTIVE USE BY WOMEN IN MARIGAT LOCATION, KENYA

M.K. Kyalo

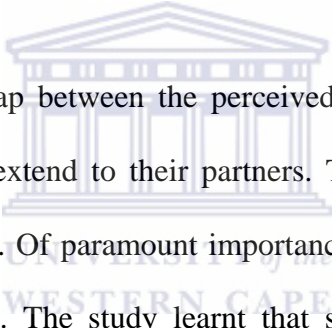
Masters in Public Health (MPH) Minithesis, School of Public Health, University of the Western Cape.

Globally, it is estimated that 120 million couples are not using contraceptives though they wish to space and time the births of their children. Power imbalance within couples is identified as one of the significant issues affecting the adoption of family planning. Modern contraception gives women a degree of autonomy that upsets prevailing power relations between men and women. The imbalance in power dynamics between men and women may lead to conflicting feelings about family planning thus affecting contraceptive use. Therefore there is need to address male participation strategies to reduce these gender tensions.

The Baringo District surveillance report (2003) indicates that the total fertility rate (TFR) stood at 7.2 in 2003, which is much higher than the national rate of 4.9 (MOH, 2003). The Marigat sub-district hospital records indicate that only 516 out of 4,150 women are using modern contraceptives in Marigat Location. Given these figures and the said power dynamics, the aim of the study therefore was to explore perceptions of men in the reproductive ages towards women who use contraception. This study in the Marigat

Location was also intended to come up with a set of recommendations on how the role of men could be enhanced in family planning.

An exploratory qualitative study was conducted using focus group discussions as a form of data collection. These group discussions were conducted with a sample of men drawn from the Marigat Location. The sample consisted of men of reproductive ages (20 - 59 years). Four focus group discussions were conducted to establish the role of men in family planning. Analysis took place concurrently with data collection. Data was grouped along the research questions then coded into relevant themes.



The study found an evident gap between the perceived benefits of FP and the actual support men are supposed to extend to their partners. This study has been explicit in elaborating reasons for the gap. Of paramount importance is culture that has influenced men's perceptions towards FP. The study learnt that sex issues formed the basis of manhood thus limiting FP discussions between couples. Other culture influence included strong desire for large families. Despite these cultural factors, men still recognize the value of FP for their wives. However, their sources of information work against this recognition. Peers have provided negative FP information the FP programme has not made efforts to counter the arising fears among men. These fears included perceived side effects suffered by women on FP and perceived immortality by women on FP. Other than peers, herbalists have been provided damaging FP information thus raising concerns in regard to communities' informal health systems and their role in FP.

The recommendations are drawn from the analysis of the study findings, the literature review and health promotion literature. More importantly, it builds on participants' suggestions; viewed as opportunities for the FP programmes. Interventions could include promotion of FP education among men, couples and community, promotion of FP through community leaders, drama, radio and role models.



## Declaration

I declare that the study on *The Role of Men In Family Planning: An Exploration of Perceptions of Men Towards Contraceptive Use By Women in Marigat Location, Kenya* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full Name..... Date.....

Signed.....



## ACKNOWLEDGEMENTS

I would like to thank:

School of Public Health, University of the Western Cape, for introducing me to wider definition of health that includes societal dimension of health which I feel is the most important aspect of health. And again, for instilling in me the passion for community health.

Dr Ruth Stern for her valuable input, encouragement and prompt feedback.

The participants in my study, who willingly shared their thoughts, ideas, feelings and time with me.



My co-researcher, Jayne Wangui, for her support in recruitment and assistance in conducting the focus group discussions.

Mr Stephen Chemjor, the Team Leader at CCF Marigat for his material and moral support during my study.

Last but not least my parents for their constant support and encouragement during my study.

## TABLE OF CONTENTS

<b>KEYWORDS</b>	
<b>ABSTRACT</b>	
<b>DECLARATION</b>	
<b>ACKNOWLEDGEMENT</b>	
<b>1.0 INTRODUCTION</b>	
<b>1.1 Study Context</b>	
<b>2.0 RESEARCH PURPOSE</b>	
<b>3.0 LITERATURE REVIEW</b>	
<b>3.1 Factors Influencing Male Perceptions</b>	
<b>3.1.1 FP Knowledge</b>	
<b>3.1.2 Sources of Information and Attitudes Towards FP</b>	
<b>3.1.3 Culture and Family Planning</b>	
<b>3.1.4 FP and Gender Focus</b>	
<b>4.0 CONCEPTUAL FRAMEWORK</b>	
<b>5.0 RESEARCH GAP</b>	
<b>6.0 STUDY AIM</b>	
<b>7.0 SPECIFIC STUDY OBJECTIVES</b>	
<b>8.0 METHODOLOGY</b>	
<b>8.1 Study Design</b>	
<b>8.2 Study Population and Sample</b>	
<b>8.3 Data Collection</b>	
<b>9.0 VALIDITY</b>	
<b>10.0 DATA ANALYSIS</b>	
<b>11.0 ETHICS</b>	
<b>12.0 RESULTS</b>	
<b>12.1 Socio-demographic Characteristics</b>	
<b>12.2 Perceptions of Men Towards Family Planning and Contraception</b>	
<b>12.2.1 Men's Interests in Family Planning</b>	
<b>12.2.2 Family Planning and Culture</b>	
<b>12.2.3 Gender Biased Program</b>	
<b>12.2.4 Loss of Control by Men</b>	
<b>12.2.5 Loss of Affection</b>	
<b>12.2.6 Men's Fears</b>	
<b>12.2.7 Some Women are Ignorant</b>	
<b>12.3 Increasing Male Participation in Family Planning</b>	
<b>12.3.1 Men as the Entry point</b>	
<b>12.3.2 Seminars</b>	
<b>12.3.3 Community-Based Distributors</b>	
<b>12.3.4 Integrating FP Education in Forums of Interest to Men</b>	
<b>13.0 DISCUSSION</b>	
<b>14.0 STUDY LIMITATION</b>	
<b>15.0 CONCLUSION AND RECOMMENDATION</b>	
<b>16.0 REFERENCES</b>	
<b>17.0 APPENDICES</b>	



## 1.0 INTRODUCTION

Family planning (FP) is a component of reproductive health. According to WHO (1994), FP implies the ability of individuals and couples to have the number of children they desire and to space and time their births through the use of contraceptives. Ross *et al.* (1989) and WHO (1994) outline the benefits of FP as reduced maternal morbidity and mortality through reduced parity, prevention of high risk and/ or unwanted pregnancies that can then be terminated through risky abortions. For the purposes of controlling population growth, FP is viewed as having positive economic and resource implications at both the local and national level (Ross *et al.*, 1989; WHO 1994).

The population of Africa increased from 224 to 728 million between 1950 and 1995, a growth rate of about 2.8% per year, which is twice the world's average (Fapohunda & Rutenberg, 1999). This is despite the existence of modern FP services for decades. There are also still quite a large number of maternal deaths that could otherwise be avoided through the use of contraceptives (WHO, 1994). Thus, there is a big gap of unmet needs relating to family planning hence raising concerns about uncontrolled population growth and maternal deaths.

Globally, it is estimated that 120 million couples are not using contraceptives though they wish to space and time their births (WHO, 1994). About 500,000 women die per year due to causes related to pregnancy and birth and approximately 100,000 of these could be saved with provision of effective FP services (WHO, 1991).

The World Bank (1993) report also indicates that 850,000 deaths per year among children under-five could be saved with effective FP.

A limited or inappropriate choice of methods and fear or prior experience of side effects, the broader issues of individuals' lack of knowledge, power imbalances within couples and families and socio-cultural, religious and gender barriers are identified as issues affecting the adoption of FP (WHO, 1994).

Fertility and FP literature has suggested that men have an important role in decision making related to reproduction and FP behaviour (Adamchak & Adebayo, 1985; Isiugo-Abanihe, 1994; Bawah *et al.*, 1999). Bawah (2002) correlates alienation of men in FP programmes to poor performance of the programmes. The need to involve men was further strengthened at the International Conference on Population and Development (ICPD) in 1994 and the 1995 4th World Conference on Women (Roudi & Ashford, 1996).

Social researchers writing about the introduction of FP in traditional African societies indicate extreme gender inequality (Adewuyi & Ogunjuyigbe, 2003; Bauni, 1994; Bawah *et al.*, 1999; Djamba, 1995; Keele *et al.*, 2005). Men feel that the decisions regarding FP should largely be their responsibility thus undermining women's power to contribute significantly to such decisions. In an African set-up, conjugal relationships are largely defined on cultural terms (Djamba, 1995), hence, men determine such terms.

But modern contraception gives women a degree of autonomy that upsets the prevailing power relations between men and women. This autonomy threatens to distort traditionally perceived reproductive obligations of women (Bawah *et al.*, 1999) wherein they are expected to have children as desired by men. Hence these gender imbalances may lead to conflicting feelings about FP and so negatively influence contraceptive use (Bawah *et al.*, 1999). Therefore there is need to address male participation to reduce these gender tensions.

### **1.1 Study Context**

The present research study was conducted in Marigat Location in Baringo, a district in Rift Valley Province of Kenya. The population of Marigat is approximately 8,442 (GOK, 1999), consisting of 4,292 and 4,150 men and women respectively. Baringo district is predominantly arid and semi-arid. The indigenous tribes in the area are Tugens and Njemps, though other tribes have infiltrated the town. Livelihoods of Marigat communities are based on small scale trading of honey, poultry, milk, goat, cattle, and crops that are mainly from the Perkerra irrigation.

#### ***Family Planning Services***

FP services are provided at Marigat Sub-district Hospital situated in Marigat town. The services are offered through maternal and child health clinics that target women in their reproductive age. The services are not available through community-based distributors; village level health volunteers in-charge of training, referral and provision of FP services.

Baringo surveillance report (MOH, 2003) indicates that total fertility rate (TFR) stood at 7.2 in 2003, which was much higher than the national rate of 4.9 (MOH, 2003).

The hospital records in Marigat showed that 500 women had used Depo-Provera and 16 were offered pills during the period from January to December 2006. Thus, only 516 women were reported to have sought FP services at the clinic from a total female population of approximately 4,150. The nursing officer reported that even though the ante-natal clinic indicated an average of 70 visits a month only an average of 41 women visit the hospital for family planning in a month. Therefore, the FP programme in Marigat is under-utilized. The clinic personnel have attributed poor performance of the FP programme to refusal by male partners and fears related to side effects.

The clinic staff find injections to be more appealing because of their "invisibility." This enables women to participate in FP programmes without the daily risk of being discovered by their male partners, a feature that is inevitably associated with oral contraceptives. Most men do not approve of the use of FP by their wives and have often accused clinic staff of having their women use FP without their consent (Personal Communication with Arafat, the Nurse in Charge Marigat sub-district hospital, 22<sup>nd</sup> January 2007).

The Medical Officer in Baringo described the programme as 'silent'. There is low use of FP services in the district (Baringo) as a whole.

At the time of the interview the district did not have an officer for reproductive health (Personal Communication with J. Otieno, Medical Officer of Health, Kabarnet District Hospital, 11<sup>th</sup> March 2007). It is unfortunate that the FP uptake is low and yet the district health management team does not have an officer for reproductive health and a rigorous FP program to intervene.



## 2.0 RESEARCH PURPOSE

Due to the crucial role that women play in child bearing, FP programmes in Africa have traditionally concentrated on reaching women through the maternal and child health services. Thus the disproportionate emphasis has been biased towards women and men have largely been ignored (Djamba, 1995). This means that women may get little support or face resistance from their male partners. Yet participation of male partners affects the choice, adoption, continuation and correct use of FP methods (Fapohunda & Rutenberg, 1999). Traditionally men have the power to make decisions regarding reproductive health (Djamba, 1995). For success of the FP programmes men can participate in two ways, either by supporting the partners' decision to use FP, or through the use of male FP methods (Roudi & Ashford, 1996).

According to Lundgren *et al.* (2005), the challenge of redirecting FP services towards greater male involvement lies in formulating effective interventions. Therefore, this study seeks to contribute towards strategies that would reach out to men to participate more in FP to increase contraceptive use and reduce total fertility rate.

### **3.0 LITERATURE REVIEW**

There is an urgent need to understand the perceptions of men towards FP and the extent to which they perceive their responsibilities in family formation and reproductive health (Khan & Patel, 1997). However, few studies have addressed men's issues related to FP; it is in this context that the study reviewed largely research on knowledge and attitudes of men in regard to FP.

#### **3.1 FACTORS INFLUENCING MALE PERCEPTIONS**

According to Downie *et al.* (1996), attitudes are linked to health perceptions and behaviours and are thus central to health promotion. Consequently, they highlight the importance of knowledge in changing attitudes and thus influencing health decisions. Thus, the literature exploring knowledge and attitudes of men will be used to understand their perceptions and consequently actions towards FP.

##### **3.1.1 Family Planning Knowledge**

There are several studies that have shown the importance of knowledge in influencing contraception. According to CEDPA (1998), education and consequently knowledge, can influence attitudes and thus perceptions leading to the questioning of traditional beliefs and practices, such as those supporting high fertility rates. This finding is supported by a study by Bozkurt and Ozcirpici (2000) which showed that the more education men have, the more likely they are to participate in contraception.

A comparative study of 14 countries, including Kenya, notes a strong association between education levels of husbands and contraceptive use by their wives (Roudi & Ashford, 1996). This has also been supported by the work of Clements and Madise (2004) during their study in Ghana, Tanzania and Zimbabwe. Albert (2003) related education levels with openness by couples to discuss sex. Likewise, De Silva (1985) correlates husband-wife communication and contraception with higher education levels.

Increased knowledge about FP by both partners correlates positively to increased uptake of contraception by women. A survey conducted in Zimbabwe shows that 98% of men have knowledge of at least one method of FP and 84% of the men approve of FP (Adamchak & Mbizvo, 1991). Similarly in Turkey, a community trial with women aged between 15 and 49 and their husbands showed that FP education given to both sexes resulted in important changes in knowledge, attitudes and behaviours as opposed to comparable education that targeted women only (Bozkurt & Ozcirpici, 2000).

However, knowledge is not the only factor. There is also evidence to show that knowledge may not always transform to positive attitudes towards contraceptive use. A number of surveys have noted high levels of knowledge of contraception among men but its use has remained fairly low.

A study by Althaus (1992) shows that 84% of the men knew of at least one method of family planning but only 6% approved of its use and only 24% have ever used FP.



Similarly, a survey conducted in Nigeria by Adewuyi and Ogunjuyibe (2003) to explore knowledge and attitudes of men towards contraceptive use among the Yorubas found that, though the knowledge of contraceptive use was high among men the use was low among couples.

Unfortunately, these two surveys do not explain reasons for the emerging pattern of high knowledge and low use. This leaves the question about why such knowledge has not translated into attitudes that support women's use of contraception.

### **3.1.2 Sources of Information and Attitudes towards Family Planning**

Ageyman *et al.* (1996) note that the sources of information available to men are also important in influencing the adoption or rejection of FP. Given that in many settings little effort is made to educate men about reproduction and FP, it is imperative to understand what men are learning, from whom and where they learn it.

Djamba (1995) cites data from a survey in Kinshasa, Zaire conducted in 1991, which showed sources of contraceptive information as 28% from friends as compared with just 7% and 8% from health staff and media respectively.

Similar findings have been reported by Khan and Patel (1997): men identified their main sources of FP information as friends (65%), media (47%) and health workers (11%) and only 6% of them mention their wives. A small number of men are getting FP information from their wives.

This could imply minimal communication in regard to FP issues among couples. However, neither study discusses the effects that information from peers would have on male participation in FP.

There is a substantial health promotion literature that addresses the gap between knowledge, attitudes and action, and one of them is the Theory of Reasoned Action. This theory is dependent on two variables, namely attitudes and subjective norms (Naidoo & Wills, 2000). Attitudes that form part of the intention are a result of individual beliefs and an evaluation of those beliefs forms the attitudes towards change. Subjective norms are influences from the significant others (social norms) that influence the intention to take action. The latter has a major influence on behavior. Therefore, decisions by men to support or to not support their partner's use of contraception may be as a result of the influences from significant others. The 'others' here refers to those they regard highly such as their own peers or parents (FHI, 2001).

The influence by significant others is elaborated in a study by Palmore and Freedman (1969) on fertility influences from those of the same networks; those of the same social groups. The study observed that people were likely to use contraception if they perceived that their associates were also using contraception. Thus people are bound to take action only when they know their peers approve of such actions.

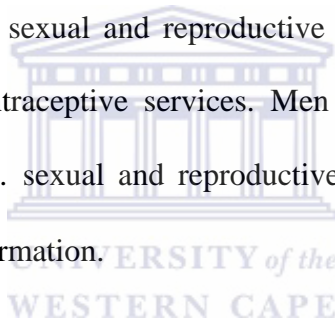
## ***Content of FP Information***

### *Information from Peers*

Feyisetan *et al.* (2003) assert that the influence from peers depends on the content of the information among other things. Though FP discussions are expected to highlight positive aspects of contraception, this may not always be the case. The authors note that discussions that highlight negative health consequences about contraception frustrate the FP promotion.

DFID (2004:8) states that,

Men often lack access to the information and services they need to protect their partners and their own sexual and reproductive health including education and counseling ... and contraceptive services. Men may play a damaging role in controlling women's ... sexual and reproductive behaviour and their access to [such] services and information.



A few studies have indicated the damaging effect that the content of FP information from peers has had on the use of contraception by women. For instance, an in-depth interview revealed that men thought modern methods would harm their spouses and themselves (Bertrand, 2003). These men also expressed concern that the pill might increase women's sexual drive to a point that was threatening to them (Bertrand, 2003). Such false ideas came from peers and friends (Bertrand, 2003). Marchant *et al.* (2004) note that service provision is perceived to be inadequate in addressing rumours and fears associated with FP.

Thus, the lack of access to accurate information on contraceptive methods can lead to misconceptions that trigger fear in men, resulting in a general unwillingness to use contraception. Therefore, the knowledge that men get from their peers may not necessarily translate into attitudes and behaviours that support contraception.

Men have also been made to believe that women use FP to conceal infidelity. In a study by Bawah *et al.* (1999) in Northern Ghana, men voiced their concerns that women who practice FP are likely to be unfaithful to their husbands. The perceived promiscuity was seen to damage men's honor and pride. Such information hinders male support for use of contraceptives by women.

#### *Information from Health Personnel*

Conversely, information from sources that highlights positive aspects of contraception may encourage its adoption and use. A number of experimental studies have demonstrated positive influences towards the use of contraception following FP education by health personnel. In Zimbabwe, FP education from health personnel encouraged discussions among couples leading to increased usage of contraception (Adamchak & Mbizvo, 1991). The Ministry of Health in Ghana began a systematic family planning Information Education and Communication (IEC) project that led to significant increases in men's knowledge and practice of FP. This also led to an improvement in attitude with the increasing length of the project (Kim *et al.*, 1992).

Likewise, an experimental study in rural El Salvador showed that there were increased discussions in FP among couples and consequently increased contraceptive use, rising from 45% to 52%, as a result of FP education from health staff (Lundgren *et al.*, 2005). Though these studies do not compare FP education from health personnel with that from other sources, results observed after dissemination of such information by health personnel show a remarkable improvement in the use of contraception.

### **3.1.3 Culture and Family Planning**

Djamba (1995) asserts that FP programmes are likely to be effective when they recognize existing cultural patterns of decision-making governing male and female relationships. The author notes that in African societies conjugal relationships are largely defined in cultural terms, which include issues of power and control (Krumeich *et al.*, 2001). Men are often the head of households and thus possess power and control of the family. The husband's attitude, preferences, intentions and decisions are more important as they exert the main influence in the couple's communication and fertility decision-making (Drennan & Robey, 1998; Chai, 1997). Such power extends to decisions on the number of children a couple would have.

#### ***Couples Communication and Male Involvement in FP***

A number of studies have shown that communication between couples regarding FP and contraceptive use is considered crucial to the adoption of contraception (Chai, 1997). These discussions are found to be positively correlated with fertility behaviour.

A survey in Nigeria by Oyediran and Isiugo-Abanihe (2002), correlated communication between couples with their fertility desires. Couples that discussed FP were 1.6 times more likely to use contraceptives than those who did not. Using the Kenya Demographic and Health Survey (KDHS) of 1989, Nyblade and Menken (1993, as cited by Djamba, 1995) found a statistically significant association between couple communication and contraceptive use. Thus communication between couples has been found to increase their ability to act together to achieve common goals (Djamba, 1995).

The literature contains some examples of successful innovative approaches. In his review of several FP studies, Djamba (1995) cites a study in Ghana that used games to encourage couples to talk about FP. The project used tournaments of games that men enjoy such as soccer and checkers to reach out to them. Both husbands and wives were recruited to compete against each other. The winners were awarded a gallon of condoms, or another prize to spark FP talk between couples. This enhanced FP discussions among couples thereby reducing wrong connotations related to FP. Half the reduction in fertility in one rural area in Ghana was associated with inclusion of men (Djamba, 1995).

A similar successful pilot project in rural El Salvador integrated FP into a water and sanitation program to increase male involvement in FP decisions and use. Discussions relating to FP in the community increased from 5% to 23% among men and by 7% to 16% among women during the intervention period. Contraceptive use is reported to have increased from 45% to 58% within the two-year project implementation period (Lundgren *et al.*, 2005).

Like most FP programmes, earlier efforts in rural El Salvador and Ghana concentrated on women. Reaching out to men required integration of these programmes into their areas of interests and development. Some of the areas included water and sanitation projects and tournaments, and in so doing managed to cater for quite a large number of men. Their inclusion into FP programmes encouraged spousal support and communication hence increased the use of contraception.

Chai (1997) suggests that issues of spousal communication across societies and their intrinsic variations might be understood in terms of the different structural and cultural factors within which the couples live. These would include such things as religious ideologies and cultural norms concerning gender roles and status that impinge upon women's autonomy. Fertility issues have been related to sexual matters, and thus are viewed as a taboo, and are consequently not to be discussed in public and even between couples (Bawah *et al.*, 1999; Djamba, 1995). In a study carried out in West Africa, nearly three-quarters of men in the study reported that they had never discussed FP with their wives; in East Africa, less than 40% of men said they had discussed it; and in North Africa, the percentage was even lower (Ezeh *et al.*, 1996). These examples highlight how cultural norms act as a barrier, preventing fertility discussions between couples.

### ***FP Decisions***

Decisions regarding contraceptive use vary and it depends upon the gender and power relations chiefly within the family (Bhassorn, 1991).

From his review of studies Bhassorn (1991) concludes that men and women believe that husbands should be the primary decision-makers regarding contraceptive use and marital sexual activity. Though women are often counseled and encouraged to use the method of their choice, men play an influential role in most households' decision-making processes (Bawah, 2002).

A survey conducted in Nigeria indicated that men had a strong influence in decision making regarding use of FP by women. In this survey about 63% of the Yoruba men involved in the study approved the use of FP as compared to just 35.7% of the women (Adewuyi & Ogunjuyibe, 2003). A review of studies by Djamba (1995) also found that men had more influence than women. Data from a 1991 survey of five urban areas in Nigeria found that while 88% and 78% of married men and women respectively reported that husbands are influential in FP decisions only 7% and 16% of married men and women reported that the women were the most influential (Djamba, 1995). The authors concluded that men play a crucial role in decision making regarding reproductive health. There are other studies in African countries that assert the domineering position of men in decisions regarding reproductive health (Djamba, 1995; Bawah *et al.* 1999; Adewuyi & Ogunjuyibe, 2003).

When partners make joint reproductive health decisions, these are more likely to be implemented. In Ghana, a wife's attitude towards contraception is strongly influenced by that of her husband (Ezeh *et al.*, 1996).



It is perceived that men have more influence on reproductive decisions, because they typically control household assets and are accepted as household heads. The study in Burkina Faso, shows that men perceive women as part of their household assets and that they are obligated to bear children, thus autonomous fertility control is out of question (Bawah *et al*, 1999).

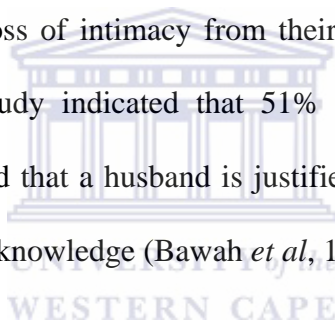
An analysis of data from 11 demographic health survey reports indicate that Kenya has the highest number of women (19.8%) amongst the listed countries that continue to use contraception against the will of their husbands (Djamba, 1995). Unfortunately, the report does not state reasons for the disapproval by men.

A study in Chogoria (Kenya) indicated that women feel more secure and comfortable with the methods they use if their husbands are involved in the decision-making process (Bauni, 1994). This further qualifies men as having an upper hand with regards to decisions on whether or not to use contraception. Since women cannot adopt any contraceptive method without their husbands' permission, such conditional approval of contraception by males could be a serious bottleneck in the acceptance of contraceptives for low parity. Therefore, women do need motivation from their husbands.

It was interesting to note that, though FP discussions among couples and the subsequent use of contraceptives were high in Zimbabwe, men did express a strong desire to control the use of contraceptives within marriages.

About 84% of the men surveyed indicated that women should not use family planning before the birth of at least one child (Adamchak & Mbizvo, 1991). The men further indicated that, though women should be allowed to seek FP information from clinics, men should be consulted before the adoption of any one contraceptive method. Thus, FP education does not seem to change the fact that men wish to remain the primary decisions-makers.

Women have had to face the wrath of their husbands' when they use FP without their husbands' approval. A focus group discussion conducted in Northern Ghana found that wives suffered beatings and loss of intimacy from their husbands' when they used FP without their consent. The study indicated that 51% and 43% of female and male respondents respectively agreed that a husband is justified in beating his wife when she uses FP without her husband's knowledge (Bawah *et al.*, 1999).



### ***Desire for Children***

Men have varied reasons for not approving contraception. The preferences for large families in large rural populations that rely on subsistence farming have strong cultural attachments (Binyange *et al.*, 1993). For instance, in parts of the Near East and North Africa and parts of South Asia preference for a male child puts upward pressure on fertility levels. Since many couples continue until a son is born, fertility is higher than would be the case without gender preference (Anderson & Baird, 1998).

In Matemwe, Tanzania, men appear to have a strong authority especially in polygamous relationships since a man with multiple wives and many children has higher a social status in the village (Keele *et al.*, 2005).

The number of children in a family is therefore an important factor, but not the only one. It has also been apparent that some men do embrace the use of FP for the sole purpose of spacing births. For example a study in Dakar, Senegal, found that there was a significant acceptance of contraception for the sole purpose of spacing births, even among men from the most conservative backgrounds (Posner & Mbodji, 1989).

Similarly, in Zimbabwe though the knowledge and approval rates of FP are high among males, fertility rates are still high. Their support for FP is mainly about spacing births. While 52.8% of those interviewed identified spacing as their reason for using FP just 5.7% of those interviewed identified resources (family income) as a consideration for using FP. Thus the men seem to be more drawn to family spacing as the main reason for using FP, hence fertility rates are still high. Reasons for valuing many children included: support in old age, bringing happiness to the family and fear of child deaths (Adamchak & Mbizvo, 1991).

#### **3.1.4 FP and Gender Focus**

Unfortunately, men's lack of access to services such as FP clinics and counseling services has been a barrier to family planning use and more importantly its approval by men.

Wambui (1995) noted that men cannot share responsibility for reproductive health and family planning if services and information do not reach them. As most of the FP clinics cater for women, men are uncomfortable about going to them. The author cites reasons for bias towards women because they bear the direct risk and burden of pregnancy and child bearing. Other reasons for this bias are that most modern contraceptives are for women and that many providers assume that women have the greatest stake and interest in protecting their own reproductive health. Reflecting these assumptions, the clinic-based service delivery design for FP has made it difficult to include men (Edwards, 1994).

However, in his review of studies Djamba (1995) found that the majority of men are concerned about the reproductive issues of their partners. This testimony from Kenya is a good illustration for their concern. A participant in a study by Wambui (1995) notes that,

After having three children, my wife went on pill for her contraception because we could no longer afford an accident ...Her blood pressure immediately shot up, and she was advised to discontinue. She tried other methods, but they had complications too. I felt I was unfair and it was my duty too to take part in family planning. One morning we went together to our local FP clinic. I will never forget how embarrassed I felt. There was not even a single man there, just queues of women and their babies. This was a woman's world and I felt totally lost.

Thus many men see maternal and child health clinics and their staff as serving only women and children.

Hence they feel uncomfortable seeking information or services in such settings. As described in the literature men need accurate information about contraceptive methods to enhance their involvement in FP matters (Djamba, 1995).

They also need to know where to go for services, counseling and to get answers to their questions (Gallen *et al.*, 1986).



## 4.0 CONCEPTUAL FRAMEWORK FOR MEN PARTICIPATION IN FAMILY PLANNING

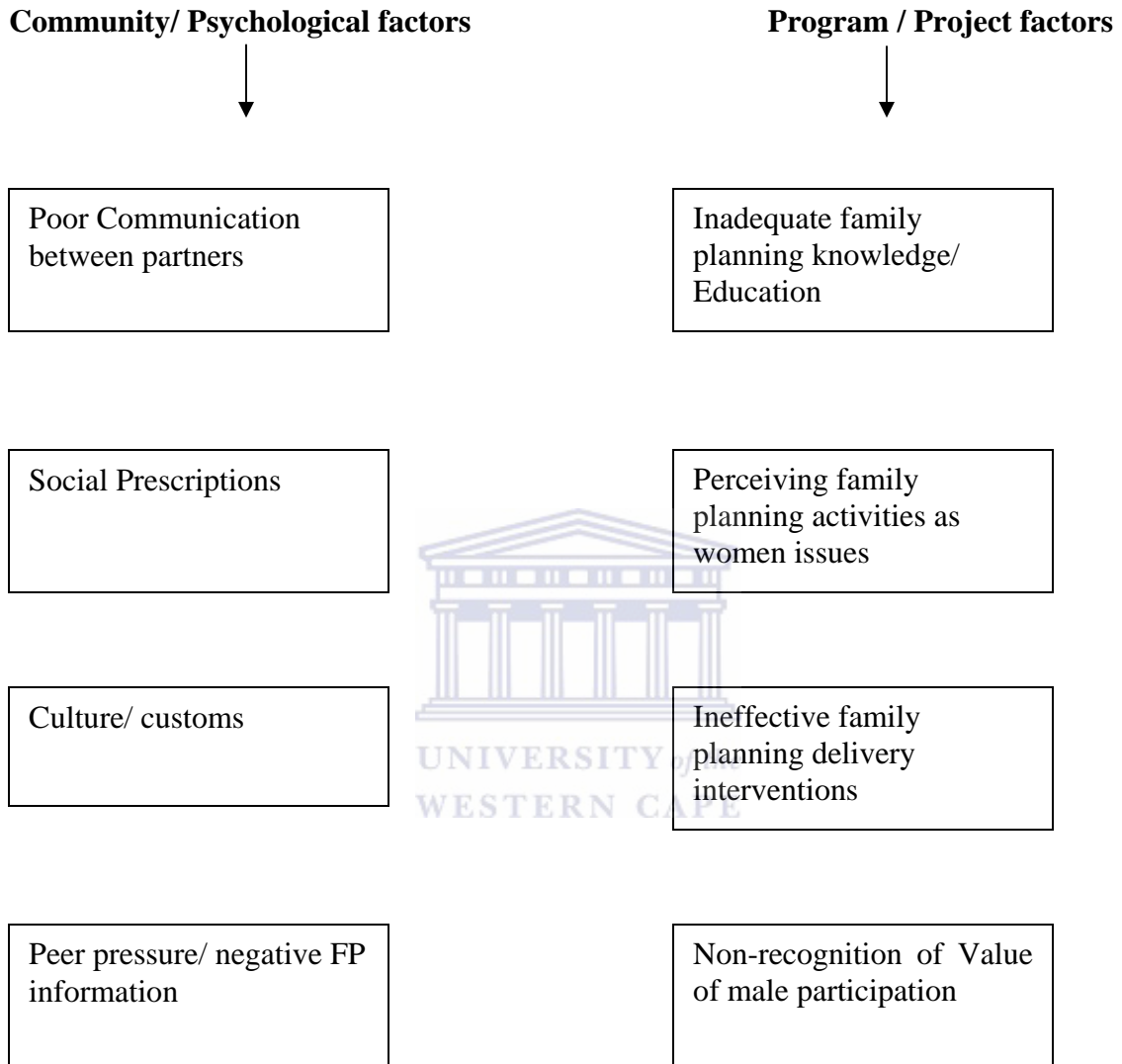


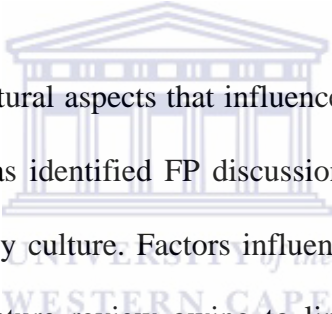
Figure 1: Conceptual Framework

The literature review has highlighted the main factors that affect male participation in FP. As shown in the conceptual framework above, these factors are divided into two categories: those specific to either individuals or the community, and those emanating from the design and delivery of the FP activities. Poor communication between partners has made it difficult for them to discuss and make FP decisions. Poor communication is shown to be an influence by social and culture prescriptions that hinder communication about sex, which is considered as a taboo subject. Culture has not only affected a couple's ability to communicate but has also put pressure on the number of children a couple should have. The literature has also presented evidence to show how negative information has affected the adoption of FP.

The FP programmes have not made efforts to educate communities, and particularly men, to demystify negative information. Similarly, such programmes have not involved men in the process and thus FP issues have been viewed as targeting only women.

## 5.0 RESEARCH GAP

The majority of studies and literature reviewed here were derived from quantitative research methodologies. There is a general scarcity of literature that focuses on qualitative research that explores perceptions of men towards contraception. However, qualitative research is increasingly being viewed as worthwhile in its own right since it allows for the development of an in depth understanding of an issue, by uncovering cultural meanings (Pope & Mays, 1995). In addition the methodology explores respondents' views; in this instance, what hinders women from using contraceptives and what could be done to promote contraception among them.



Few studies have identified cultural aspects that influence male perceptions with regards to FP. The literature review has identified FP discussions, FP decisions and desire for children as being determined by culture. Factors influencing such perceptions have not come out strongly in the literature review owing to limitations of the data collection approach (quantitative). Furthermore, culture may vary from one community to the other thus understanding cultural aspects hindering contraception by women in Marigat will be important.

There is also a need to understand the gap between knowledge, attitudes and behaviours that men develop and consequent actions they take in regard to contraception by their partners. It has been interesting to note that peers do play a major role and more importantly a damaging one, as the content of FP information peers spread is often negative.



However they are not entirely to blame since the FP clinics are not doing much to counter this damaging information. There is therefore a need to understand men's sources of FP information and the content. Hence, this study attempts to contribute by adding the observations from a qualitative study, to give more insight into *why* some of the attitudes and behaviours exist, and consequently, to suggest context appropriate recommendations for male involvement in Marigat, Kenya.



## **6.0 STUDY AIM**

To establish the role of men in modern family planning in Marigat Location, Kenya with the view to making recommendations on how such roles could be enhanced

## **7.0 SPECIFIC STUDY OBJECTIVES**

- To explore the perceptions of men aged 20 - 59 years towards family planning in Marigat Location
- To explore the perceptions of men aged 20 - 59 years towards contraceptive use by women of reproductive ages in Marigat Location
- To explore opinions of men with regard to increasing their participation in family planning activities and programmes in Marigat Location



## **8.0 METHODOLOGY**

### **8.1 Study Design**

Qualitative research is increasingly being viewed as worthwhile in its own right: It helps us to understand social phenomena in natural surroundings and emphasizes the meanings of experiences and views of the respondents (Pope & Mays, 1995). Gifford (1996) emphasizes the need for public health strategies to consider the realities of life and its ambiguities in order to be effective.

Fertility issues are defined in cultural terms (Djamba, 1995). Thus, issues of family planning are subjected to existing cultural norms. This was demonstrated by a fertility survey in India, where Stone and Campbell (1984) noted that family planning surveys in developing countries encounter special problems of contextual bias since contraception issues are considered private and are culturally sensitive. The authors crosschecked with some of the respondents and realized that certain terminologies were misunderstood hence questions were answered incorrectly. Again, some participants felt that some questions were personal hence they gave incorrect answers to avoid being judged. Basically, the quantitative approach limited the understanding into issues of fertility.

Rubin and Rubin (1995:51) noted that,

The field of reproductive health is full of puzzling questions, complicated relations, and slowly evolving events; phenomena leaving gaps in understanding that invite qualitative methods to fill.

The research described here is an exploratory qualitative study. The approach was enriched by a detailed description of community perceptions, attitudes and preferences and it also gave contextual descriptions with culturally specific information (Mack *et al.*, 2005; Stone & Campbell, 1984).

### *Focus Group Discussions*

Focus group discussions (FGD) were selected as the method of data collection. They have the advantage of producing quality data, allowing group interaction to become a source of data, and give the researcher the opportunity to view the participants within their natural social world (Wilkinson, 1998). The researcher is able to tap into many different forms of communication that people use in day to day interaction such as jokes, anecdotes, teasing and arguing. Analysis of such interpersonal communication, the researcher can identify shared and common knowledge and attitudes of the people. Although, in some instances, FGDs may display ambiguity, this is not viewed as a defect, but is rather appreciated as a faithful reflection of the subject matter (Bloor *et al.*, 2001). Participants may hold conflicting views on a particular subject but that implies the reality on the ground. In addition, tapping into interpersonal communication highlights cultural values and group norms (Kitzinger, 1995).

Cassidy (1994) identifies focus group discussion as a culturally sensitive technique. FGD uses simple questions with few words to minimize cross-language misunderstandings.

The tool comprises of open –ended questions and the researcher can track the discussion, using probe questions depending on the participants’ thinking and language, hence allowing for flexibility of questions from setting to setting (Greenbaum, 2000). Thus the technique allows the respondents to freely expose their understanding of the issues, values, perceptions, using their preferred language. Consequently, content analysis of the FGD data reveals deep understanding of issues without infringing on the participants culture (Cassidy, 1994).

Consciousness-raising may be one of the by products of FGDs, or it can be actively introduced and encouraged by researchers, by devolving power and reciprocity. (Wilkinson, 1998). The FGD participant may develop a clearer sense of the social and political processes through which their experiences are constructed, and perhaps also a desire to organize against them. Particularly when discussing sensitive subjects such as sex, the group acts as a supportive environment where ideas can be shared and participants spark off thoughts in others (Kitzinger, 1995). Power is transferred from the researcher to the participants, defining issues and drawing actions (Grbich, 1999). Rather than have the researcher as the expert, FGDs allow respondents to develop their own agenda, hierarchy of needs, use their own terminology and discuss issues in the manner they deem best and draw actions that they relate with. Thus, FGDs are an opportunity for public participation (Bloor *et al.*, 2001).

Therefore, perceptions of men on FP captured verbally in a group context will be drawn on to make recommendations to the Marigat Sub-district hospital on how to maximize their participation in FP.

## **8.2 Study Populations and Sample**

The study population consisted of men aged 20 – 59 years within Marigat Location. This is a small area and participants already know each other, thus it was easier for them to relate to each other and bring along shared experiences (Bloor *et al.*, 2001; Coreil, 1995).

In qualitative research, sampling strategies are designed to produce information-rich cases that yield detailed understandings, explore meanings, processes, interpretations and theory on reproductive issues (Rice & Ezzy, 1999; Gifford, 1996). Purposive sampling was used to select the respondents of the focus groups in order to strengthen these interactions.

## **8.3 Data Collection**

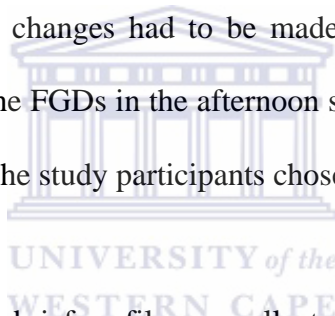
The recruitment of study participants and data collection took place in November 2007. The participants were drawn from neighbourhood groups <sup>1</sup>working with Marigat Child and Family programme. The leaders of the eight neighbouring groups adjacent to Marigat town assisted the researcher to select four men aged 20 – 59 years from each group to participate in the FGDs.

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<sup>1</sup> A neighbourhood group is made-up of 18 – 25 neighbouring households. Marigat Child and family Programme has divided the community into neighbouring groups with similar socio-economic status through which they implement developmental programmes.

Of the initial 32 participants recruited only 25 participants attended the focus groups. During the recruitment process, candidate participants expressed some discomfort towards the nature of the research topic. Low attendance can also be attributed to the fact that the study was conducted during a busy farming season. Thus, either one or both of these factors could have contributed to the low attendance.

Four focus group discussions were conducted each with 6, 6, 7 and 6 participants respectively. Each focus group took place on a separate day with a day's break in between for the researcher do some initial analysis to check for issues that required further clarifications and whether any changes had to be made for the future groups. All the participants preferred to have the FGDs in the afternoon since most of them had to attend to their farms in the morning. The study participants chose the venues for the FGDs.



Before the start of the session, a brief profile was collected from each participant. This was done mindful of the advice by Ulin *et al.* (2002) who noted that participants' profiles help to enliven the report; describing the samples, interpreting their speech and analyzing emerging themes with respect to contextual differences.

The purpose and nature of the research were explained to all the participants in the first session. Participants who were not comfortable talking about their own personal experiences were assured that they did not have to. However, they could relate other people's experiences if they found that easier.

This allowed participants to relax and understand that the study was biased towards their opinions rather than disclosing personal decisions regarding FP.

The participants warmed up easily to the researcher since she had been working with the community. The fact that both the researcher and the co-researcher were women did create some tension but it did not deter the participants since both had lived and worked within the community for years.

Sessions began with general conversations on the happenings in the villages so as to reduce the tension. Traditionally this sort of strategy is used to reduce tension at the start of meetings in the villages. Normally, a representative from each village would give an overview of what is happening in the village before the meeting starts.

Then the participants set ground rules to establish mutual respect among researchers and group members. The participants were reminded not to discuss details of the content of the discussion once they left the focus group site.

The researcher developed a focus group discussion guide (Appendix 1) to facilitate comprehensiveness and systematic data collection. The guide was flexible to adapt questions to participants and circumstances (Ulin *et al.*, 2002). Discussions were conducted in Swahili (the second Kenyan national language) since it was commonly used in the area and the researcher was more comfortable using it.



The researcher was the principal facilitator while an assistant researcher was present to assist in moderating sessions and take notes. The proceedings were tape-recorded and notes were taken on what could not be captured on tape (body language).

## **9.0 VALIDITY**

Both raw and processed data was stored for confirmability (Bloor *et al.*, 2001). Hence the study process is open to outside inspection and verification to make clear distinction between researcher's ideas and those of the study subjects (Ulin *et al.*, 2002). To strengthen the aspect of credibility, the researcher compared the findings of the study with comparable findings available in literature for such things as similarities and new patterns.

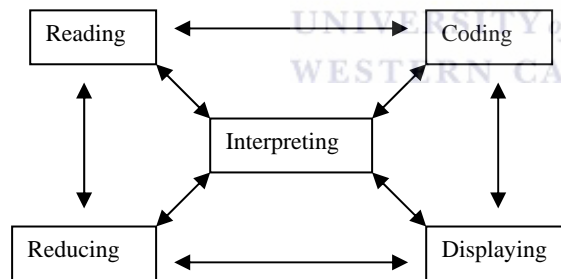


Before closing the sessions, the researcher reviewed the discussions and emerging patterns for confirmation with the participants. Having four FGDs enhanced triangulation of data. Debriefing sessions between the facilitator and assistant facilitator took place immediately after focus group discussions to review and analyze results from each session, thus enhancing researcher triangulation (Gifford, 1996). The researcher kept a diary of personal thoughts and opinions throughout the research process. These notes were used in the making of the final study report.

## 10.0 DATA ANALYSIS

Analysis was done manually; this enabled adequate interpretation of findings (Coreil, 1995; Gifford, 1996). The process took place concurrently with data collection to allow for review and critical reflection of emerging patterns and issues and further clarifications were sort in subsequent data collection (Gifford, Undated). The data collected was analyzed through thematic content analysis (Gifford, Undated) to identify themes and patterns that emerged across and within the groups. These data were coded and categorized and analyzed. The themes are illustrated with direct quotes from the discussions.

The strategy for the data analysis is summarized in the figure below;



Adapted from Huber & Mills 1994: 429

Figure 2: Graphical Summary of the Data Analysis Process.

After each session, the research team read and re-read their field notes to understand and verify whether the information collected matched up with the questions.

The notes were then reduced to emerging themes then displayed so that similar themes could be coded and grouped together ready to make a report. Interpretation took place throughout these processes to identify and explain core meaning of the data.

To conclude the study, the researcher drew together the findings of the study and the literature review issues shown in the conceptual framework. Therefore, the researcher will be in a position to make recommendations as informed by the research findings.



## 11.0 ETHICS

Approval for the study was obtained from Marigat Child and Family Programme. Each of the participants was provided with a letter explaining the research study and requesting their participation (Participant's Information Sheet Appendix 2). The consent was sought and a consent form was available for the participants to sign when they participated (Participant Consent Form Appendix 3). Participants were made aware that participation was voluntary and that they could withdraw had they wished to. Since the research used FGDs and members already knew each other confidentiality could not be assured, but it was requested from the participants. Ethical approval was also obtained from the University of the Western Cape.



## **12.0 RESULTS**

This section starts with a summary of socio-demographic characteristics to give a description of the participants in the study. This is followed by a description of men's perceptions towards family planning and use of contraception by their partners. These perceptions are put in the form of themes that emerged during the FGDs. The section concludes with description of ways that participants felt would enhance their participation in FP.

### **12.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS**

The ages of the participants ranged from 25 – 65 years. The ages ranged as follows: eight between 25 – 30 years old, nine between 31 – 40 years old and 8 between 41 – 65 years old. Though the study intended to recruit males within the age range of 20 59 years, one of the participants who attended the FGDs was beyond the age brackets. The researcher felt this would not affect the data collected. Participants' education level ranged from basic education to college; eight respondents had basic education, eight were high school graduates and three were college graduates. Six of the participants had not received any formal education.

Only six participants reported use of contraceptives by their partners while nineteen did not use contraceptives. This question only captured the use of modern contraceptives though none of the participants claimed use of any other form of family planning methods. On average, the participants desired to have seven children.

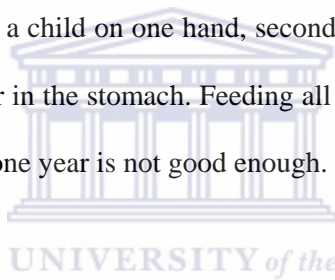
## **12.2 PERCEPTIONS OF MEN TOWARDS FAMILY PLANNING AND CONTRACEPTION**

### **12.2.1 Men's Interest in Family Planning**

The FGDs revealed that participants clearly described and understood FP. They described FP from three main perspectives; spacing of children, family resources (family income) and mother's health.

The participants described FP as being in position to space children. One participant (a community trained nurse) described spacing as follows:

You see a mother holding a child on one hand, second one on the head, third on the back and still carrying the other in the stomach. Feeding all these children becomes a problem. Spacing children for just one year is not good enough.



The family should be able to comfortably fend for the children especially their basic needs. But the picture that the community paints during the discussion is that of more children than the families can fend for. Some argued that, due to menopause mothers should have children in close sequences (which meant no spacing) so that age does not catch up with them.

FP was linked to family resources (family income). Most participants felt that resources dictated the number of children a couple would have. It was argued that having more children than the available resources meant that the children would go without basic needs such as food, clothing and education. FP was also viewed as a means to curb poverty rates in the community.

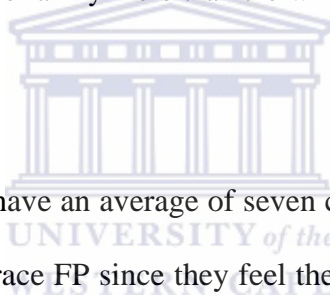
A 36-year old participant reiterated that:

The rich just have two children but those of us with nothing have many children. Many children means clothing will be a problem. You see the white just get two children.

But some participants felt the poor had many children so that the children would take care of them. In addition, those with several girls meant incoming wealth from payment of dowry.

A participant added that:

The man wants to limit the family more than the wife since it is him who will strain as the breadwinner.



In the profiles, men desired to have an average of seven children while in the discussions they affirm their desire to embrace FP since they feel the pinch of having a large family. Their strong desire for children seem to override what they interpret as benefits associated with FP.

The other advantage attributed to FP was to help keep the mother's health in check. Participants felt that spacing children for two or three years would give the mother time to gain strength and take care of the other children. The older generation expressed concern that while in the past husbands had to slaughter goats for the nursing mother till she recovers; lately young men do not value the healthy tradition. They also claimed that family planning was deeply valued in the older days.

A 65 year old participant said that:

Long ago, culturally there used to be some form of family planning. Once a child is born the man has to wait till the child is grown to sleep with the wife. The child would be asked to touch the belly of a goat or be sent to bring a stick. When the child can do these, the man can then go into that house.

FP then was meant to space children but not to limit the number of children.

Some participants argued that, in the past most men were polygamous and that it would not be possible to abstain for very long periods and nowadays men can only afford to marry one wife.

Pills and the injection were the methods of FP common among the study participants. The participants seemed to know very little about contraceptives and how they are meant to work in a woman's body. It was noted that, most of the participants believed that contraception had permanent effects, causing infertility in women. Others suggested that short-term methods should be devised. The participants did not seem to realize that both pills and injections were actually short-term FP methods.

### **12.2.2 Family Planning and Culture**

#### ***Value for many children***

Though participants seem to embrace FP, they still equate the number of children one has as providing both family stability and security for the future. Some participants were of the opinion that FP curtails the two expectations. Having many children meant the parents would have people to fend for them when they are old.



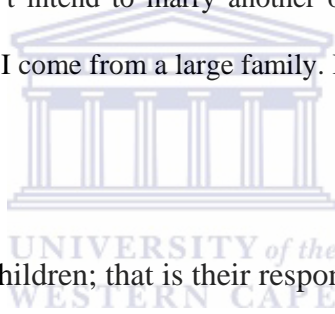
And again the more children one had the higher the probability of having sons who would in turn ensure continuation of the family lineage.

This view was captured by a 39 year old participant who had no formal schooling, who said that:

During our past, family planning was not put into consideration since many children were regarded as wealth and thus men married several wives.

A 27 year old participant who had a high school education added that:

I come from a polygamous family; my dad has two wives and we are fifteen children. I have one wife and I don't intend to marry another one. I cannot have two children it would be ridiculous since I come from a large family. I plan to have at least five children. FP is out of question!



Women are supposed to have children; that is their responsibility as viewed by men. Men perceive use of FP as a long-term event that could risk the prospects of having more children. Traditionally it is men who are entrusted with the responsibility of determining the number of children a family should have. Women risked having co-wives if they were known to use FP. Hence women had to keep having children if they wanted to remain relevant in the family.

One participant (a high school graduate) reported that:

A friend of mine had a fight with the wife the other day. After having two children the wife is not getting pregnant again. The man wondered what was happening-could she have gone for the injection. He warned her against using those things. He was telling me that if she does not conceive he would have to marry another wife.

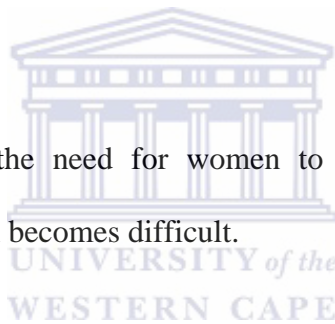
### *Sex Discussions are a Taboo*

FP is a sex related subject. In this particular community sex issues are very sensitive and are a taboo not only in public but also between married couples. Participants felt that sex forms the basis of manhood. Therefore it is a taboo for a woman to talk about FP whilst the man cannot talk about the same because he risks exposing his manhood. It is a dilemma!

A 28 years old college graduate describes the situation as follows:

Men would like to discuss family planning with their wives but the difficulty comes when the men cannot discuss sex issues with women; owing to traditional men ego. Sex is the basis of manhood.

While some men expressed the need for women to discuss with them FP issues, communication in this situation becomes difficult.



### **12.2.3 Gender Biased Program**

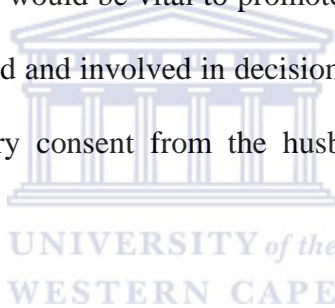
Yet, despite the above cultural emphasis on men, FP is viewed as woman's business since it is women who give birth, and the focus is entirely on them. The participants unanimously expressed their agitation towards the FP programme for sidelining the 'decision maker'. From packaging to the delivery of FP services, women are the focus. The FP clinics mainly focus on the woman. The FP education and services are tailored to suit the needs of women, ignoring men. Thus men feel excluded and their role diminished to a mere observer.

This is highlighted in the statement quoted from a 42-year old participant who said that:

The clinics are making a mistake; they focus only on the women. They teach the women about FP and they expect us [men] to go along with it. No way, I cannot be fooled like that.

The FP program has not recognized men who are the primary decision makers in the homes. Such exclusion of men has led to their retaliation, which is manifested as a general aversion to the use of contraceptives by their partners.

Incorporating men in FP issues would be vital to promote contraception by women. Men felt they too need to be educated and involved in decisions regarding FP by their women. Some advocated for mandatory consent from the husband before a woman receives contraceptives at the clinic.



On a positive note, men expressed their willingness to participate in FP if their role is recognized. Several participants said (as summed up by a 45-year old participant):

If men were educated, they would talk the same language with the women.

A 28 years old respondent:

If the bigger number of students in family planning school were men, it would be easy to initiate discussions on family planning.

A 30 years old respondent:

The men would take the 'world cup' if they were the ones to take the message home.

There were mixed reactions as to who should initiate the FP topic at home. Some participants felt the woman should discuss with her man first before contraception; implying the woman initiates. Others felt since the clinics should use men as the entry point; they should be ones to initiate. Given that discussing sex issues and thus FP is taboo, tension rises as to how these discussions should be conducted and who should actually initiate.

#### **12.2.4 Loss of Control by Men**

##### ***Family Planning Decisions***

Participants were overwhelming of the opinion that in decisions regarding the number of children, both partners should make decision regarding timing and the method of FP to be used by the mother. A number felt strongly about the man being the ultimate decision maker; the man is the breadwinner and the rightful person to make decisions in the home. Most participants complained bitterly that women did not involve them while making decisions regarding FP; some women use FP without the consent of their husbands. Responding to the statistics that the researcher shared from the Marigat health center, a respondent interpreted the data as follows:

Most likely three-quarter of the number that went to seek for family planning services at the health center are single since they are just the ones making the decisions.

Another respondent added:

Some women are taught at the clinic and instead of coming to ask their husbands they just decided to use FP on their own.

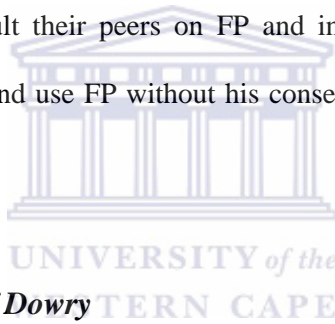
Participants felt that their authority as the head of household was threatened when women decide to use FP without their consent. Even men who approved FP insisted that such decisions must be made with their knowledge and consent.

### ***Influence by Peers***

Participants also voiced the concern that women were advised by their peers whom they referred as ‘hard-headed women’. They felt their wives just took FP advice from their peers thus undermining the man’s patriarchal authority.

A respondent complained bitterly:

Sometimes women consult their peers on FP and instead of first discussing with the husband, they go ahead and use FP without his consent. The man feels an outsider runs his home!



### ***Conflict from Non-payment of Dowry***

Payment of dowry to the women’s family is of great significance; the woman belongs to the man, she is bound to live under his rules and respect his authority. Traditionally, dowry would bind the woman to the man such that, if she dares sleep around the man can report to the elders, and as a punishment they can spell a curse on her. Deterioration of cultural values and poverty levels couples in the community have resulted in ‘come we stay<sup>2</sup>’ arrangements. Thus some women are defiant to their husbands’ rule, and the men loose control over their women. Women are free to mingle with other men. The men claimed in this situation, women end up having many children.

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<sup>2</sup> A scenario where a couple decides to live together in absence of an official marriage.

A participant noted:

Recently there is no formal dowry thus women are free and men have no control. He cannot report to anyone. Women would not reason with the men thus men couldn't participate in FP since they have no rights. They end up having as many children as their men.

### ***Alcoholism***

In this particular community alcoholism among men and women is rampant. The men argued that women who are alcoholic end up having sex carelessly and there are thus disagreements in the home. In instances where both partners indulge in alcohol it is often difficult to discuss FP matters too. The couple ends up with more children than they can fend for. The aspect was sharply raised in one of the focus group situated at a squatter settlement (Kampi Turkana) within Marigat town.

A respondent explained:

These women do not care anymore. She leaves the husband at home with the children then she goes to drink [taking alcohol]. She gets high and she fools around with other men and does their thing. When she comes home the man is upset and is high too. They both bring children from their affairs. The house is noisy because of quarrels, just when do they talk about FP?

### ***Libido***

There were mixed opinions on whether some FP methods (the men referred to pills and injection) increased or reduced libido in women. Of greater concern to participants was increased libido in some women. Their men are unable to satisfy them and hence may seek extra marital affairs.

A concerned participant said:

I have heard some women get hot [increased libido] when they use pills. They cannot have enough from their men thus end up sleeping with other men. And anyway why would a man work so hard when very well knows his efforts are futile. These things [pills] break-up home!

### **12.2.5 Loss of Affection**

Failure by women to use FP in Marigat was also attributed to fear of loss of affection by the husbands. Two main reasons were highlighted for loss of affection. First, women's reduced libido due to use of contraceptive forcing men to seek satisfaction elsewhere. participants seem to blame both increased and reduced libido to contraceptive use. Secondly, it was men loss of affection for their wives for using contraceptives since they cannot conceive. A respondent stated:

Why would I want to cultivate land that is barren? My efforts would be futile!

The threat of such disapproval could lead to a man getting another lover or even marrying another wife. This seemed like the hold men had on their partners for using contraceptives.

### **12.2.6 Men's Fears**

#### ***The Side effects***

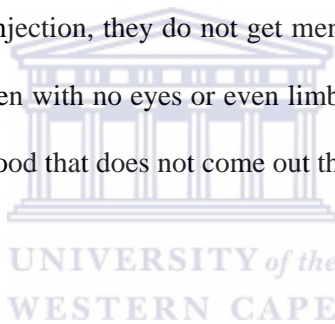
Contraceptives are viewed with suspicion. Though participants showed understanding of FP and its importance a large number of men did not understand how the contraceptives work to prevent pregnancy.

Though newspapers, radio and peers were a source of FP information, peers were prominent; often providing wrong conflicting information. The participants feel clinics have not done much to provide the much-needed information to them, and they felt the clinics had something to hide. The participants strongly believe contraceptives are not good for their women and are a threat to procreation.

It was interesting to note that participants regardless of their education status held these perceptions on side effects.

A community health nurse explained:

When women go for an injection, they do not get menstrual flow for a long time. Hence they end up having children with no eyes or even limbs. They are likely to have children with problems. It is the blood that does not come out that causes these problems.



A nursery school teacher said:

Some women suffering from inherited diseases like asthma would not go for FP because their health would deteriorate further.

A 28 years old (high school graduate) respondent added:

I heard a woman had a baby born with the sign of the cross on its face. It was the coil that had stuck on the baby as it grew in the womb.

### *Herbalists*

The community relies on herbs for treatment of ailments. On market day's herbalists conduct sensitization on their products. Herbalists have raised suspicions about modern contraceptives.



They down play effectiveness of the modern FP while marketing their herbal contraceptives. The community in Marigat has traditionally relied on herbal therapies for FP and even common ailments.

A respondent reported:

The herbalists tell us that the pills for family planning will be helpful for a while but later the chemicals will be harmful to the woman. I would rather have my wife use herbs that I understand but not pills.

### ***Woman's Infidelity***

The men were overwhelmingly concerned that women who use contraceptives are unfaithful. Women use contraceptives to conceal their affairs with other men. The women would not become pregnant with other men since they are on contraceptives thus their men would not discover their secret affairs. Single women were perceived as the ones likely to use contraceptives since they have many affairs. Therefore married women opting for contraceptives are viewed with suspicion. Women's perceived infidelity is likely to threaten men's status and ego.

Participants felt insecure that they would be unable to control their partners if they were on contraceptives. Thus FP disapproval is also meant for men to keep control of their women. Some tagged FP approval on trust they would have for their partners. Hence if the woman cannot be trusted then she cannot be allowed to use contraceptives. This raises concern about FP communication between couples.

Are the couples communicating the importance of them using contraceptives so that it is not viewed with suspicion?

An agitated respondent said:

Women, who are not loyal to their husbands, use FP since they plan to have extra marital affair.

Another respondent added (a high school graduate):

I am not against FP but I need to be aware, and of course it will depend on the trust I have for my wife.

### **12.2.7 Some women are Ignorant**

A few men argued that some women were ignorant and would not use contraceptives. Though some men embraced FP their women will just not agree to use family planning. Some attributed the ignorance to high illiteracy rates among their women, which meant that they might find it difficult to understand FP and how contraceptives work in their bodies. The perception of men was that FP education needs to be simplified to catch the eye of the illiterate woman. The men claimed that FP is viewed more for the modern woman than for all classes of women. Thus, the illiterate woman feels it is not meant for her. Some men noted that some women decide not to use contraceptives so that they punish their husbands for their unfaithfulness. The woman gets many children so that the attention of the husband is concentrated on his large family. In some instances they have many children with the intention of making their husbands happy by giving them many children.

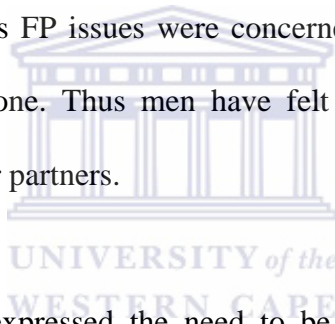
A respondent noted:

Some women refuse to use family planning so that they have many children to keep their men from marrying other women.

Some indicated that, since most of their women are delivering at homes whilst these services are offered at the maternal child clinics, it means FP services do not reach women who deliver at home. This again depicts gap in delivery of FP services in Marigat.

### **12.3 INCREASING MALE PARTICIPATION IN FAMILY PLANNING**

Despite mixed reactions towards FP, men did feel they had a role to play in supporting their partners' contraception. There are tensions arising from planning and delivering of FP programme. Men felt the FP programme as a whole and thus their partners had down played their role too. As far as FP issues were concerned they felt their role had been more passive than an active one. Thus men have felt sidelined and irrelevant hence retaliating on use of FP by their partners.



Participants overwhelmingly expressed the need to be considered in the planning to delivery of the FP programme to enhance their participation. If their role to support their partners' contraception was to be realized, the FP programme must expand its focus to include men. They felt providers should have them in mind while designing the programme so that they have strategies for reaching them. Following the description of their perceptions in the previous section it is apparent that men are not happy with FP programme for assuming their role.

### ***12.3.1 Men as the Entry Point***

In this community, the man is the main breadwinner and thus the one making the decisions in the home. Furthermore the man makes the rules in his home; hence some felt if the FP programme were to woo the man the partners would definitely adopt contraception.

A respondent suggested:

Men have an upper hand in regard to FP. It would be easy for men to convince women and if they disagree we will command them.

Participants were of the idea that since men were the determining factor in regard to use of contraception by their partners, providers needed to target them first; have men as the entry point. A respondent noted:

The best entry point for FP messages should be men since they are the ones to give green light.

The FP providers should first sensitize and educate men on FP then the men would convince their partners to go for FP. But their partners would need to consult with the men before adopting a certain method. This meant the FP programs are to target the men first, through which a woman can be reached. This would ensure that the man is aware and in control of their partners' contraception.

### *12.3.2 Seminars*

Participants felt it was important to hold seminars with married men and youths (young men). They suggested that these sessions should be held separately for the married men and youth.

A respondent suggested:

Those people from the clinic should have seminars for married men and others for youths. Men need to be taught about FP so that they understand contraceptives.

They felt the focus on the youth would ensure they understand FP at an early age rather than learn once married, which they thought, was a bit too late.

The participants were concerned about the content of the FP education that should be taught to them. A respondent explained:

They [providers] should tell us how those things [contraceptives] work and the effects they have so that we know which ones to use.

Owing to negative information that men have regarding use of contraceptives, they felt that the training should not only address methods available but how they work to prevent pregnancy and the possible effects they would have on their partners and their new-born babies. At this point some participants attributed their disapproval on two issues. First, it was the lack of information from the relevant authorities: the FP providers. Second, the negative information they were getting from their peers in the community. Hence the FP providers should make an effort to teach them.

Some participants felt that some women needed to be educated on FP as much as the men. This was attributed to the fact that some women were not conversant with FP. Others were taught at the hospitals and would not understand or were afraid to ask questions. These sessions would promote understanding of contraceptives as well as cultivate interests to adopt them. Again, they proposed that these sessions are to be held separately, for men and women.

A concerned respondent said:

We cannot sit in the same place with women and talk about FP, it is not good. Like we said our culture does not allow.

Men cannot have same sessions with women since it is a taboo to discuss sex issues with both sexes present. Participants earlier suggested the need to have their wives consult them before adopting contraceptives but they have difficulties having FP talks with their partners. They feel their manhood would be exposed.

### ***12.3.3 Community Based Distributors***

There was expressed need for the return of community-based distributors (CBDs). These were trained community persons that teamed up with FP clinic staff to train, distribute and refer women for contraceptives. They held these training sessions and distributed contraceptives door to door in the community. The FP programme in Marigat had stopped training and supporting CBDs in the community.

A 40 years old respondent recalled:

Sometime ago the clinics used to train women from the community on FP. These women came training us at home. Of course they were chased from some homes but it was good because some couples actually started using FP. It was evident because those couples did not have many children.

The participants felt these CBDs would reach men since men would not accompany women to the FP clinics. Alternatively, some participants suggested that rather than having only women CBDs as before, the FP programme could train men for an easy rapport with men in the community.

A respondent suggested:

Having men talk to men about FP is much easier. Men will not feel comfortable women discussing these issues with them and anyway culturally it is not good. They will be chased!

#### ***12.3.4 Integrating FP Education in Forums that are of Interest to Men***

The participants felt the FP discussions could be integrated into forums such as HIV/AIDS and agriculture seminars, where men were largely involved. During the sessions it was suggested that FP issues could be sneaked in. This way, men would not feel uncomfortable. It was feared that if men were to be invited for FP educational sessions as suggested in the earlier sections very few men would have the courage to attend. FP was largely viewed as a woman business thus men would fear to be associated with such meetings.

It is interesting to note that as much as men want to be educated they also have strong reservations about attending FP educational sessions. Hence a section of participants felt that integrating these sessions into other forums would reach a larger audience and demystify the fears.

Community Chiefs' meetings that are largely attended by men were an example of a forum suggested by the men. The issues discussed in these meetings are mainly about development projects in the community. Chiefs are highly respected in the community and their word is taken seriously. This would make it more likely that men in Marigat will take FP education seriously.

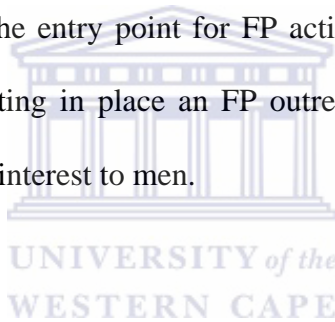
### **Summary of the Results**

Participants seemed to understand importance of using FP: spacing of children, family resources and mother's health. But despite this, they were concerned that FP would limit their offspring that has important cultural implications. The FGDs revealed strong cultural attachments to large families. Culture also determined FP communication in the community and between couples. FP subjects have been associated with sex issues, which unfortunately are a taboo and believed to form basis of manhood. Thus it is difficult for a woman to initiate such topic with the partner whilst the man cannot do the same because it would hurt his ego. The discussions have had mixed reactions as to who should make the FP decisions. Some felt both partners should make the decisions, but the majority of the participants felt it was a decision that rests only with the man.



Participants were agitated at the fact that some women were using FP without their consent. Other issues perceived to hamper FP discussions included non-payment of dowry to their wife's family and alcoholism particularly by women. In addition, men had perceived fears that prevented them from approving contraception. These included their partner's increased libido from use of contraceptives, use of contraceptives by their partners to conceal affairs with other men and side effects from the use of contraceptives. Peers and herbalists were often the source of this misinformation.

Participants did suggest ways in which their participation could be enhanced. These included recognizing men as the entry point for FP activities, holding FP seminars but separate men and women, putting in place an FP outreach activity and integrating FP education in forums that are of interest to men.



## 13.0 DISCUSSION

It is apparent that men play a role in the observed low usage of contraception by women in Marigat. However, a range of complex issues emerged from FGDs that might have directly or indirectly contributed to the disapproval by men. These views seem to span strong cultural concerns, planning and delivery of FP services. Culture seems to have influenced gender tensions that have frustrated FP discussions, fertility decision-making and consequently the use of contraception. Thus, FP was seen as bringing about a war of supremacy between the partners. Alienation of men by the FP programmes has affected their participation. Other than culture, the information gap seems to be one of the likely missing links between FP knowledge and intended actions by the men.

### **Culture and FP**

#### ***FP decisions***

Literature has indicated that culture determines issues of power and control in a social setting (Krumeich *et al.*, 2001). Given that men are often the head of households in an African setting, they possess power and control of the family. The husband's attitudes, preferences, intentions and decisions are seen as more important as they exert greatest influence in the couple's communication and fertility decision-making (Drennan & Robey, 1998; Chai, 1997) thus determining the number of children a couple would have.

The man is recognized culturally as the decision maker. This was apparent in the discussions often shown through such strong emotions particularly, anger and agitation.

The men felt their patriarchal position was threatened and that the FP programme is perceived as devaluing the position of man in the Marigat society. The programme does not introduce its concept with proper respect to traditional community values, which would place men as an integral part of the FP programmes. The appreciation of the need to integrate FP ideas within the traditional values as an effective way to win wider acceptance of FP has been recognized (Keele *et al.*, 2005). The suggestion by Keele *et al.* (2005) that the FP programme could actually consider men as active participants is useful as it validates the fact that they are vital decision makers.

In Marigat, the need to recognize men is clearly demonstrated by their anger at being sidelined, and their implied position that they be the entry point for FP in the community. There was a strong and unanimous perception that the FP programmes need to expand their focus to include them. They felt that they had an important role to play and participate in supporting their partner's contraception.

FP literature has also shown that though women are often counseled and encouraged to use the method of their choice, men play an influential role in most household's decision-making; including reproductive health (Bawah, 2002). A number of studies have indeed shown the strong influence that men have in decisions regarding use of FP by women (Adewuyi & Ogunjuyibe, 2003; (Adamchak & Mbizvo, 1991; Bauni, 1994; Bawah, 2002; Ezeh *et al.*, 1996). Studies by Adewuyi and Ogunjuyibe (2003) in Nigeria and Bauni (1994) in Kenya demonstrate that women are, in fact, secure with the role that men have in influencing decisions regarding FP.

Such role has been attributed to the fact that men control households assets and are accepted as households heads (Ezeh *et al.*, 1996).

In Marigat the situation reflected the role of men, though there was some mixed reaction as to who should ultimately make the fertility decisions. While the majority felt the decision should rest only with the men, some participants were of the opinion that they should share the decision. Thus men felt the FP programme had turned a blind eye to this fact.

Furthermore, participants were provoked by the fact that some of their women make decisions and adopt contraceptives without their consent. Thus women were overstepping their boundaries. Similar perceptions were evident in Northern Ghana (Bawah *et al.*, 1999), where such women were perceived to be deviant and thus suffered beatings and loss of intimacy from their husbands. The issue of punishment or rather physical abuse did not come up during the study in Marigat but the agitation depicted strong disapproval by the participants. It is important to note a similarity in both scenarios (Northern Ghana and Marigat) where men refrained from intimacy with their wives as a punishment for using FP. However, in the Marigat context it went further, as the use of FP without the man's consent made the men feel that their efforts for procreation were futile.

Other than women making FP decisions on their own, of greater concern to men, was the perception that their women were influenced by peers to adopt contraception. Thus having another party assume the role is threatening to the authority of the man.

Though a strong provocation for men in Marigat, this finding was not evident in the literature review.

### ***FP Communication and Taboo***

A number of studies have shown that communication between couples regarding family planning and contraceptive use is considered crucial to the adoption of contraception (Chai, 1997; Djamba, 1995; Lundgren *et al.*, 2005; Oyediran & Isiugo-Abanihe, 2002). For instance in Nigeria couples were more likely to use contraceptives when they discussed FP (Oyediran & Isiugo-Abanihe, 2002). Unfortunately, the cultural norm in Marigat, that the subject of sex subject is taboo, has discouraged FP communication between couples and thus affected contraception in Marigat.

The men argued that their women ought to discuss their choice of FP with them and seek their consent. This, however, creates a contradiction. Given the taboo, sex issues cannot be discussed in public or even between partners. The influences on spousal communication on fertility of the various structural and cultural factors, such as cultural norms and gender roles within societies have been demonstrated in several studies (Chai 1997, Bawah *et al.*, 1999; Djamba, 1995; Ezeh *et al.*, 1996). These studies, however, do not explicitly describe the cultural norms that make sex subject a taboo. The study in Marigat contributes to this gap in analysis, although it is important to note that these could very well be context specific.

The paradox in Marigat, is that the culture defines sex issues as the basis of manhood, and it is therefore the man who has the mandate to initiate fertility discussions. Unfortunately, because the FP programme has not educated men, they are not in a position to initiate such discussions or make informed decisions. Furthermore, FP discussions are perceived as exposing their manhood. Yet, women whom the FP has focused on cannot initiate the discussion for the fear of hurting their man's ego. This is a dilemma because both the delivery of FP programme and perceived culture hinder FP discussions.

Other factors have been attributed to poor communication between couples in Marigat. These may be context specific because the researcher could not relate them to other studies. First was the reference to deviant women due to non-payment of dowry by the men. Second was the rampant alcoholism in the study area resulting in disagreements between couples. These disagreements meant the environment for FP communication was further compromised. Furthermore, due to perceived infidelity that is related to drunkardness, it is highly likely that men would disapprove the use of contraception by these women. Though alcoholism does not feature in other studies, deviance as a result of non-payment of dowry does reflect a study in Northern Ghana (Bawah *et al.*, 1999).

### ***Desire for Children***

In the study, culture determined number of children a couple desires, although this was influenced by practical considerations. The men embraced the importance of spacing their children to maintain the health of their woman.

Of greatest concern, though, was the participants' dilemma in balancing family income and desired number of children. Yet, from the comments made during the discussions, the men did not want to limit the number of children.

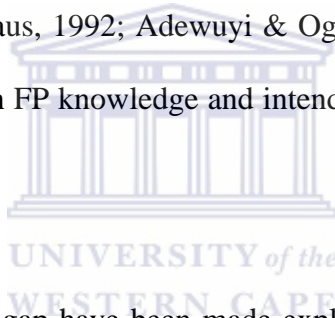
The issue of resources (family income) in regard to FP did not come out strongly in the literature review. The study in Zimbabwe (Adamchak & Mbizvo, 1991) did indicate that men considered financial stability as a reason for use of FP but spacing was more pronounced. Thus fertility rates continued to be high despite high contraception rates (Adamchak & Mbizvo, 1991). Several other studies have also demonstrated spacing as a major reason for men to approve use of FP (Drennan *et al.*, 1998; Posner & Mbodji, 1989; Khan *et al.*, 1997; Adamchak & Mbizvo, 1991). Child spacing in Marigat was valued, but limiting the number of children was not.

The Marigat study therefore reveals contradictions in regard to number of children, parity and importance that men attribute to use of FP. Though participants complained about reduced resources and increasing poverty levels, the desired number of children, which in fact averaged 7, did not reflect these sentiments. It is ironic that men identified FP as one of the strategy to combat increasing poverty levels, while the reality as depicted by their comments during the FGDs is totally different.

The tension between the culture and FP service provision was once again evident. In this instance, the cultural values attached to large families were not considered, which again meant that culture dominated over the FP ideas.

## **Peer Influence and Content of FP Information**

Discussions with the participants certainly revealed that a gap does exist between FP knowledge that men have and their intended actions. Intended actions here refer to the ambivalence between the support of contraception for the women, against their suspicion about the autonomy it gives the women. Men need to be empowered with knowledge on family planning, to form perceptions that in turn influence their attitudes on contraception so as to support their partners. Several authors have correlated FP knowledge with positive attitudes in support of FP (Bozkurt & Ozcirpici, 2000; Adamchak & Mbizvo, 1991). But there are also some studies that have found a gap between FP knowledge and intended fertility actions (Althaus, 1992; Adewuyi & Ogunjuyibe, 2003). Unfortunately, the reasons for the gap between FP knowledge and intended action were not explained in these articles.



In Marigat the reasons for the gap have been made explicit. Influence by peers and the content of FP information that they have been given, including misinformation, along with the lack of formal FP information and education by the FP programme, have resulted in men forming attitudes against contraception.

Though participants had identified other sources of information such as radio and newspapers, the discussions revealed that most of their FP information came from their peers, and it is this information that they used to base their arguments against FP.

Unfortunately it is also the information used to make decisions regarding the use of FP by their partners.



The disconnect between knowledge and intended actions that is largely influenced by peers is demonstrated by the Theory of Reasoned Action (Naidoo & Wills, 2000), in this instance suggesting that men are more likely to use contraceptives if their peers are using them. This pattern is illustrated in the literature, with several studies indicating that peers are the main source of FP information for the men (Feyisetan *et al.*, 2003; Khan & Patel, 1997; Djamba, 1995; Palmore & Freedman, 1969)

The content of FP information is identified as key to the adoption of FP. Importantly; the peer influence in Marigat had led men to believe that women who use contraceptives are bound to be immoral owing to perceived raised libidos and possibilities of preventing extramarital affair pregnancy. Such damaging information has reinforced the disapproval of FP by men. These claims of infidelity have also been evident in Northern Ghana (Bawah *et al.*, 1999). Given the above, it is highly unlikely that men would consider using FP. These findings are supported by the study by Marchant *et al.* (2004) that showed how similar concerns led to the unwillingness by men to participate in FP. Unfortunately the FP clinics in Marigat have not done much to address the misinformation and these rumours.

The participants had wrong and conflicting information regarding side effects caused by use of modern contraceptives. It was unfortunate that men did not understand how the contraceptives worked to prevent pregnancy. Instead their understanding was based on speculation. With this kind of information, it is likely that men felt they could not allow their women to use contraceptives.

This has been clearly described in Bertrand's (2003) study, which demonstrated that men were likely to disapprove FP if they thought it would cause harm to their spouses and themselves.

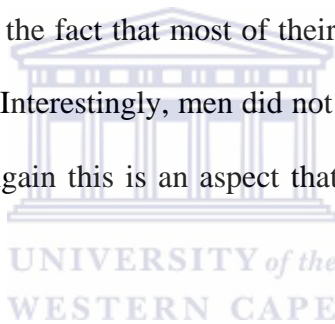
The participants in this study have indicated that FP programme is partly to blame for the misinformation by putting disproportionate focus on women while ignoring men, who have therefore felt excluded. This has reinforced their disapproval of FP, and their reliance on peer information.

The Marigat study made a revelation pertaining herbalists and the role they played in FP. In addition to peers, herbalists had contributed greatly in distorting FP information among the men, which raises concerns in regard to communities' informal health system and their role in FP. Yet none of the studies that the researcher consulted had identified herbalists and the damaging role they played in use of contraceptives.

Interestingly, even the educated and youth were influenced by these rumours. There is evidence that level of education does influence use of contraceptives (CEDPA, 1998; De Silva, 1985; Djamba, 1995; Roudi & Ashford, 1996). In Marigat, only eight out of the twenty-two participants had attained high school education. Thus it is possible that low education status has contributed to low contraception by women in Marigat. However, comments by some respondents contradict this.

Examples include the high school graduate who said the father had many children hence felt obliged to have many children too, and a community-trained nurse who associated use of contraceptives by women with subsequent fetal congenital malformation. This shows the complexity of the issues, and it illustrates the point made earlier that knowledge is only part of the solution.

The participants had paradoxical views as to who should be blamed for low contraception use in Marigat. On the one hand, they blamed the FP programme for inconsiderate packaging and delivery while on the other they blamed women's illiteracy for low contraception rates. They cited the fact that most of their women were illiterate and thus they could not understand FP. Interestingly, men did not view themselves as a hindrance to the use of FP in Marigat. Again this is an aspect that was not noted in the literature reviewed.



Tones (1995) argues that for one to actualize a certain health action there need to be a supportive environment so that the gap between a good intention and actual action is addressed. Women intending to use FP require a supportive environment so that they can use FP. The FGDs have revealed an unfortunate situation for women in Marigat. Though they would have FP information from the maternal and child health clinics the environment at home and the community is not supportive. The husband is sidelined by the FP providers, misinformed by peers and restricted by culture. As a result the husband retaliates thus disapproving of FP.

The larger community has its own expectations too; a woman is supposed to have children to prove her stay in the family and bring status to her husband. The FP programme has also not given women a supportive environment to make their FP choice a reality. Their interventions are not taking into consideration other prevailing factors that are preventing women from enjoying contraception. These prevailing factors include; male involvement, cultural believes surrounding fertility issues and misinformation from peers and community at large.

### **Opportunities for Male Involvement**

Findings, such as those by Djamba (1995) have shown that men are actually willing to participate when given a chance, and that they want to learn. Despite the resistance to FP, the study participants have shown an interest to participate and learn about FP. Though there was evident dissatisfaction with the FP programme, the men did realize that their participation would be very important. The discussions were useful as they did bring to their consciousness the need for men to support their women. It is important for the FP programme to involve them to enhance their participation by expanding the focus to include men. The men felt that the FP programme has a duty to educate them. This would enhance their understanding and clear fears they have towards FP. Consequently; it would empower them to engage in meaningful discussions with their partners, and thus promote contraception. The findings therefore clearly demonstrate the need for the service providers to realize the importance of the involvement and consent of the male partner for adoption of contraceptives by women.

Unfortunately both male and female FP providers have been trained to deliver services to women. FP clinics have been viewed as a place for just women. The Kenyan study by Wambui (1995) illustrated this by showing that though some men would want to accompany their wives to the clinic, the presence of just women made them feel lost. Similar reasons have contributed to men shying away from FP clinics in Marigat. While men advocated for their inclusion in education and decisions regarding contraception none of the respondents admitted to having accompanied their partners to the clinic. Men felt they would be perceived as ‘weak’; going to a place that is only meant for women. Hence their suggestions, reinforcing those of Djamba (1995) were that they would prefer to have sessions away from the clinic and preferably conducted by male providers.

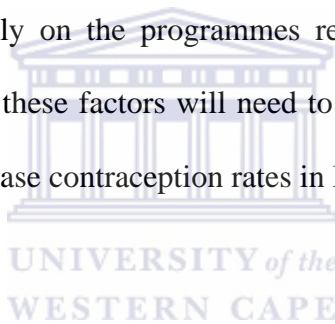
Djamba (1995) asserts that these sensitive subjects are themes that husbands and wives need to be able to talk to each other about if they are going to use contraceptive effectively. FP education directed to both partners have been proved to be effective. Of particular note are the two experimental studies conducted in rural El Salvador (Lundgren *et al.*, 2005) and Ghana (Djamba, 1995) that have included men in FP. The interventions have led to significant improvements in FP communication between couples and collective actions in regard to FP (Lundgren *et al.*, 2005; Djamba, 1995).

Lundgren *et al.* (2005: 174) notes that,

The effort to reach out to men in the context of broader development effort holds promise, especially in countries where traditional gender roles and divisions prevail, where reproductive health remains a “women’s concern,” and where gender inequities impede spousal support and communication.

The men in Marigat, however, do not foresee such joint education intervention as in Ghana (Djamba, 1995) and El Salvador (Lundgren *et al.*, 2005). Instead, they want separate education sessions for them and for the women, as their culture has made them uncomfortable about sharing the same forum with women.

It is unfortunate that men in Marigat do not yet recognize culture as a factor influencing their perception towards contraception. As a result, they are not confronting the cultural aspects that discourage FP. Indeed culture and misinformation from peers were the main factors halting FP adoption but men did not take these into cognizance. Rather, men felt success of FP depended greatly on the programmes recognizing men as the primary decision makers. However, all these factors will need to be put into consideration when designing interventions to increase contraception rates in Marigat.



### **Potential Interventions**

It is important that the suggestions of the participants in Marigat, developments from the literature review, researcher's analysis, theories of behaviour change in health promotion literature and evidence obtained from an appraisal of the research are used to inform FP interventions in Marigat. Use of theoretical foundations to recommend actions provide a substantial basis for interventions (Rendall-Mkosi *et al.*, 2006). Similarly, use of evidence from quality research improves selection of appropriate and effective interventions (Raphael, 2000; Wiggers & Sanson-Fisher, 1998) that are likely to benefit the community in Marigat.

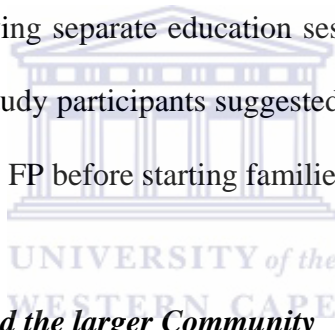
It is evident from the FGDs that men have inadequate knowledge regarding FP, and that FP knowledge is important to increase contraception (Bozkurt & Ozcirpici, 2000; Adamchak & Mbizvo, 1991) Therefore, it will be important to have in place interventions geared at providing FP education to men. An FP education package should reflect the needs and concerns of men in Marigat. Men have made it clear that they are not comfortable learning FP from the clinics, which are viewed as a place for women. Rather, FP programmes should be decentralized particularly training and sensitization to reach men and the wider community.

### ***Community Based Distributors Program***

Participants identified community-based distributors (CBDs) as one way to enhance their participation in FP. In the past the FP clinic in Marigat had trained community persons as CBDs, who in turn trained couples at homes, held community trainings, distributed contraceptives and made referrals to the FP clinic. Though the programme faced tough times with the men, participants admitted it had made considerable strides in increasing contraception, an observation noted elsewhere by Muhwava (2002) who found that availability of CBDs does increase demand for contraceptives. Study participants suggested that a number of males be among CBDs that would be trained, a sentiment also voiced by Djamba (1995); the need to train male family planning providers to offer appropriate information to men. Therefore revival of the CBDs programme will boost contraception with special focus on including male CBDs in the programme.

### ***FP Education***

Because culture makes it difficult for men and women to have open discussions about contraceptives, study participants preferred to have FP education sessions separate from with women. However, Djamba (1995) strongly recommends joint sessions to demystify these tensions. Enabling couples to engage in fertility discussions enhances effective use of contraceptives through increased spousal communication and joint decision-making. The examples set by studies in Ghana and El Salvador (Djamba, 1995; Lundgren *et al.*, 2005) are useful for Marigat because reaching out to both men and women in their areas of interests is likely to increase contraception rates in Marigat. Alternatively, the FP programme could consider having separate education sessions for men and women then scale-up to joint sessions. As study participants suggested, FP education need to focus on the youths so that they embrace FP before starting families.



### ***FP Education for the Peers and the larger Community***

Though men have other FP sources such as radio and newspapers their perceptions of FP seem to have been influenced largely by peers than the two sources. The study has shown that information provided by peers is often wrong and misleading, particularly information on side effects and perceived infidelity by women. Men use this conflicting information to make decisions hence prevent their women from using contraceptives. Therefore it will also be vital to factor in peers who were the main source of FP information for men and the larger community for FP sensitization and education.



Other than the male partners the study has shown that women are not getting motivation from the larger community either. This intervention will promote a supportive environment for women to use modern contraceptives.

### ***Re-training of Health Workers***

Experimental studies in Zimbabwe and Ghana (Adamchak & Mbizvo, 1991; Kim *et al.*, 1992) have demonstrated positive influences to the use of contraception following FP education by health personnel. Thus there is need to re-train health workers in Marigat to deliver a more effective culturally sensitive FP services.

### ***Communication of Innovations***

This sort of communication seeks to enhance spread of new ideas and social change among populations in a particular community (Glanz, 1998). The author emphasizes the need to consider the anticipated social change, the communication channel and the existing social structures, norms and networks. The norms in Marigat do not favour open discussion of sex matters but for the change to occur conversations on FP in the community have to be encouraged.

Community leaders such as local chiefs could be used to sensitize community on FP. The chiefs (low ranking government representatives) are viewed as credible and also seen as symbol of power. Actually study participants did identify chiefs meetings as one forum that FP sensitization could be encouraged.

In addition, chiefs could be trained on FP community awareness so that they can pass messages to the community over time during community forums and in the long run influence adoption of desirable behaviors towards FP. Downie *et al.* (1996) notes that use of opinion leaders as a source of information is an effective strategy where peer pressure and peer support play a role in influencing attitudes and behaviour.

### ***Health Drama***

Social change could also be channeled through drama. An evaluation of channels used in community-based IEC HIV/AIDS intervention in rural Uganda found drama highly acceptable and content of message well understood by the community (Mitchell *et al.*, 2001). Evaluation participants felt drama bore close resemblance to their own lives.

They recognize themselves in the drama, thus reflecting real life situations. The authors assert the need to have discussions follow the drama for the purpose of educating and clarify issues raised during the play. This would rule out the occurrence of the audience taking home the wrong message. Even as the participants ask questions the tension that is related to FP will begin to wear-out.

### ***Social Learning Theory***

Social learning refers to acquisition of information from others of the same network/setting (Feyisetan *et al.*, 2003; Soldan, 2004). This theory highlights that people learn not only from their experiences but also from observing the actions of others and the results of their actions. A study by Palmore and Freedman (1969) on implementation of FP programme in Taiwan depicts fertility influence from those of same networks.

The study observed that people were likely to use contraceptives when others in their network were perceived to be on contraception than those who perceived that others were not using. Couples and particularly men in the community would be convinced to adopt contraception if they saw others in the community who had or are using contraceptives and benefits. Thus, FP programme in Marigat could use FP role models that can be emulated by couples in the community.

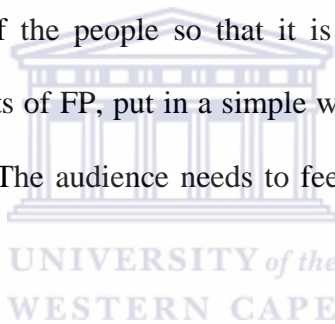
### ***Radio***

Studies in Malawi and Zimbabwe have indicated radio as a main source of FP information for men (Adamchak & Mbizvo, 1991; Soldan, 2004). For instance in Zimbabwe, the study showed 98% of the men having FP knowledge and significant improvement in contraception rates. However, radio did not come out strongly as a source of FP information for men in Marigat thus it has not influenced contraception. Hence there is need to examine how the FP messages are packaged and delivered through the radio. Unfortunately there is no community radio in Marigat.

However, a radio station that uses Kalenjin (one of the main tribes in Marigat) was recently launched and it is widely listened by the locals. The FP programme could use the station to sensitize community in their local language. Of course using local language will enhance understanding.

This intervention could borrow from the Yale-Hovland Model, which describes persuasive communication that focuses on source, audience, message and medium through which message is conveyed (Rendal-Mkosi *et al.*, 2006). Repeated exposure to these four elements in a well-coordinated package enhances attitude change.

The information needs to be presented in way that will be attractive and have immediate impact so that it is accepted and retained (Downie *et al.*, 1996). The source should be credible and the community has to relate with the person delivering the message; for instance a man could be used to encourage other men to use FP. The message must capture needs and concerns of the people so that it is useful and relevant. Messages should focus on positive aspects of FP, put in a simple way and too far from the cultural beliefs it could risk rejection. The audience needs to feel that the message is meant for them and they need to act.



The above interventions should consider basing the FP information on participatory formative research with the community to enhance usefulness, relevance and ownership of the FP programme by the community. Krumeich *et al.*, (2001) noted that interventions targeting health behavior have little chance of success when social and cultural issues are not put into consideration. It is also important that interventions are not seen to clash with cultural values attached to FP. Rather FP messages could be integrated within cultural values. Keele *et al.* (2005) warns that working within African culture is critical. The authors suggest participation in FP by men should be viewed as a benefit rather than a threat.

For instance, men could be taught that using modern contraceptive increases sexual stamina and makes women physically strong. Again, since men typically control decisions regarding fertility, it is critical FP programme actively involves men.

#### **14.0 STUDY LIMITATIONS**

**Small study:** The sample size is small so the study cannot be generalised to either the whole community or other comparable settings. Rather, the results can be used to support existing literature or add new perspectives on the topic. But, it is worth noting that literature on the topic is limited.

**Time and costs constraints:** The researcher did not conduct FGD till data saturation but limited FGD to only four groups. This was a valid sample, given that the study was for a mini-thesis.

**Member Validation:** The researcher will not be able to present her final analysis to the study subjects to discuss the results before the final report of the study is submitted. This is due to costs and time constraints that the researcher is likely to face.

**Conducting research in Swahili:** Using Swahili for the focus groups discussions could impact on the power balance within focus groups tipping in favour of the researcher and away from the participants. Some participants had difficulties using Swahili fluently thus the assistant researcher assisted in translating to both the participants and the researcher.

**The sensitivity of the research subject compounded by the fact that sex is taboo:** In Marigat community it is a taboo to discuss sex issues in public. Thus, it is a likely possibility that could have prevented some participants within the focus groups to answer questions truthfully and completely.

## 15.0 CONCLUSION AND RECOMMENDATIONS

The men in Marigat do understand the value of FP and the benefits it would bring to their partners and their families. But the support they have extended to their partners in regard to use of FP so far is limited. Thus, there is an evident gap between the perceived benefits of FP and the actual support men are supposed to extend to their partners. This study has been explicit in elaborating reasons for the gap. These reasons could be context specific but it does contribute greatly to the strength and appreciation of qualitative research.

Of paramount importance is culture that has influenced men's perceptions towards FP. Similar to other settings; sex issues are taboo thus affecting contraception. The study learnt that sex issues formed the basis of manhood thus limiting FP discussions between couples and community at large. Consequently, women cannot initiate FP discussions or share the FP information with their men while men cannot make the decisions since they are not informed, hence a dilemma. Other cultural influence included strong desire for large families. Similar to other settings as depicted by the literature review, FP has been preferred for spacing though contraception is low in Marigat.

Despite these cultural factors, men still recognize the value of FP for their wives. However, their sources of information work against this recognition. Peers have provided negative FP information the FP programme has not made efforts to counter the arising fears among men. These fears included perceived side effects suffered by women on FP and perceived immorality by women on FP.

Other than peers, herbalists have been provided damaging FP information thus raising concerns in regard to communities' informal health systems and their role in FP.

Several studies have indicated strong association between education levels with FP use. The study in Marigat has reflected on these findings but it has revealed that education may not always be part of the solution. Even, the educated had negative perceptions in regard to FP use, with negative information in the community and more importantly culture, seeming to override male support for FP. Paradoxically, though findings did indicate that low contraception in Marigat was largely due to limited support by men, some participants felt illiteracy by some women was responsible for the women's limited use of FP. They felt FP was designed for the 'sophisticated woman'.

Therefore, this study presents the need for improved FP programming that seeks to understand and thus integrate its ideas within the culture in Marigat. The programme should promote male involvement and more importantly, shared responsibility for reproductive health. Fortunately, the men realized they had a role to play thus presenting an opportunity for the FP programme in Marigat.

### **Recommendations**

The recommendations are drawn from the analysis of the study findings, the literature review and health promotion literature. Importantly, it builds on participants' suggestions; viewed as opportunities for the FP programmes.

The participatory approach also enhances usefulness, relevance and ownership of the FP programme by the community. The following are the recommendations that the FP programme could adopt:

- FP education targeting men has been viewed as key to wider acceptance of FP services in Marigat. Again literature has shown joint education sessions as more effective. Thus the FP programme in Marigat could promote education among couples, integrating it within their areas of interests. Alternatively, FP education could target men and women separately then scale-up to joint sessions. FP education that focus on the youth is likely to promote its use when they start families.
- Re-training of health workers with focus on the study findings to deliver a more effective culturally sensitive FP programme
- The FP programme in Marigat could consider decentralizing FP programmes through re-introduction of community-based distributors (CBDs) to reach men and the community at large. It would be vital to recruit men too as CBDs for wider acceptance.
- Chiefs' *Barazas*<sup>3</sup> that are largely attended by men could be avenues for FP promotion. The FP programme could also consider training chiefs on FP so that they pass the messages since they are community resource persons.
- The FP programme could make use of FP role models; couples who have successfully used FP and are ready to share their experiences, to promote FP.

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<sup>3</sup> Chief Barazas refers to the weekly meetings held by the location leader, the chief. The chief is a government appointee meant to promote government policies, and ensure law and order in the community.



They could be encouraged to participate in FP education sessions and FP outreach programmes in the community.

- Drama is powerful in conveying health messages. The FP programme in collaboration with community groups in Marigat could consider integrating drama within FP education or social gatherings.

It is important that the drama is followed by reflections and discussions of the issues shown and the community perceptions for effectiveness.

- The FP programme in Marigat in collaboration with local radio station could consider airing FP education and adverts with appropriate packaging using the Yale-Hovland Model.



### **Issues for Further Research**

A couple of issues have emerged from the Marigat study that were not evident in the literature review and thus present opportunities for further study. The perceived influence by peers on contraception by women provoked men in Marigat and thus seemed to influence their disapproval. Secondly, alcoholism by women came strongly as a factor that too influenced the male disapproval. These two issues could be studied; to understand to what extent and how they affect contraception by women.

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## **17.0 APPENDICES**

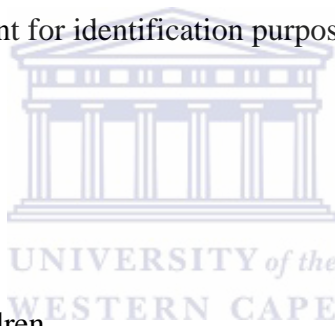
### **APPENDIX 1**

#### **FOCUS GROUP DISCUSSION GUIDE**

##### **Participants Profiles**

Before the sessions commence, privately collect background information of the participants. Assure the participants of confidentiality on the information provided. Give a tag number to every participant for identification purposes.

- 1 Age
- 2 Level of education
- 3 Use of contraceptives
- 4 Desired number of children



##### *Guide Questions*

1. What is family planning? / What methods of family planning do you know? /
2. What are your sources of family planning information?
3. What is your opinion on family planning/ who do you think should use family planning
4. Who makes decision on Family planning
5. What are your opinions on use of contraceptives by women
6. What are the socio-cultural issues that promote or hinder family planning



7. How do men participate in family planning/ how do you promote their  
participation



8. What are the major fears that men have concerning family planning

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### PARTICIPANT INFORMATION SHEET

**Project Title: The Role of Men In Family Planning: An Exploration of Perceptions of Men Towards Contraceptive Use by Women In Marigat Location, Kenya”**

#### **What is this study about?**

This is a research project being conducted by student Mary Koki Kyalo at the University of the Western Cape as a partial fulfillment for the requirements degree of Masters in Public Health (MPH). We are inviting you to participate in this research project because you can contribute valuable information - as a male of reproductive age in Marigat towards the research questions. The purpose of this research project is to gather and analyze data in view of giving recommendations to promote male participation towards contraceptive use by women in Marigat Location.

#### **What will I be asked to do if I agree to participate?**

You will be asked to

- 1 Attend the sessions that will be held at your convenient agreed location near your village.
- 2 Give your profile which includes your age, level of education, use of contraceptives and desired number of children, before the sessions start, to help in writing up the report. This process will take less than five minutes and it will be confidential
- 3 Participate in a focus group discussion to deliberate on perceptions that men have towards contraception use by women. The group discussions should take about two hours, to start and end at your own agreed time.
- 4 During the sessions, discussions will be audio-recorded to help in collecting data.

The following are the questions that will guide the discussions.

1. What is family planning? / What methods of family planning do you know? /
2. What are your sources of family planning information?
3. What is your opinion on family planning/ who do you think should use family planning
4. Who makes decision on Family planning
5. What are your opinions on use of contraceptives by women
6. What are the socio-cultural issues that promote or hinder family planning
7. How do men participate in family planning/ how do you promote their participation
8. What are the major fears that men have concerning family planning

**Would my participation in this study be kept confidential?**

We will do our best to keep your personal information confidential. To help protect your confidentiality, we shall not use your name but numbers for the profile and during the discussions. All the raw data, notes, audio-tapes and investigator's research diary will be safely locked in the cabinet that only the investigator shall have access. We shall also request other participants for confidentiality. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

**What are the risks of this research?**

There may be some risks from participating in this research study. Some participants may feel embarrassed/ uncomfortable discussing the research questions since they are related to sex or even sharing their personal experiences before other participants.

**What are the benefits of this research?**

This research is not designed to help you personally, but the results may help the investigator learn more about the role of men in family planning in Marigat Location. We hope that, the recommendation from this study will help promote male participation in contraceptive use by women.

**Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time.

If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify

### **What if I have questions?**

This research is being conducted by Mary Koki Kyalo, a student at the University of the Western Cape. This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

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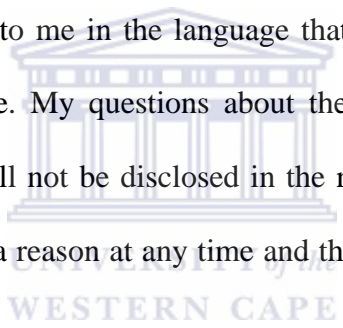
Email: [rstern@uwc.ac.za](mailto:rstern@uwc.ac.za)

**APPENDIX 3**

**CONSENT FORM**

**Title of Research Project: The Role of Men In Family Planning: An Exploration Of Perceptions of Men Towards Contraceptive Use By Women In Marigat Location, Kenya.**

The study has been described to me in the language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed in the report and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.



***Participant's name.....***

***Participant's signature.....***

***Date.....***