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## FACTORS INFLUENCING UPTAKE OF FAMILY PLANNING SERVICES AMONG MEN IN KENYA

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### ABSTRACT

**Background:** Utilisation of family planning services in Kenya remains quite low hence, the soaring population which has partly hampered achievement of the fifth Millennium Development Goal (MDG) as well as achievement of overall development goals for the entire country. Current reports indicate that male participation improves uptake of maternal healthcare and family planning services among women.

**Objective:** To determine factors that influence male participation in family planning services in Kenya.

**Design:** A retrospective study

**Setting:** Nationally representative survey of Eight provinces in Kenya.

**Subjects:** Married and single sexually active men.

**Results:** From the adjusted logistic regression model after controlling for other factors, we found higher education AOR 1.59 (C.I: 0.767-3.299), employment AOR 1.67 (C.I: 1.127-2.496), Media as the source of information AOR 1.75 (C.I: 1.308-2.367), discussion with a health worker AOR 1.71 (C.I: 1.206 – 2.430), number of wives (one wife AOR 0.07 (C.I: 0.007-0.769), No more desire for children AOR 2.83 (C.I: 1.794-4.489) and the total number of children one has (1-4) AOR 2.55 (CI: 1.616 -4.029) as the main factors that influence male participation in family planning services.

**Conclusion:** In Kenya, programmes intending to have men actively participate in family planning services should focus on addressing multiple factors which influence men's participation in family planning services.

### INTRODUCTION

Fertility rates remain highest in sub-Saharan Africa and it is projected that this trend will continue (1, 2). The rising population in this region is a growing cause of concern since this is likely to interfere with the realisation of the development goals. Kenya, a resource-constrained country within this region, has continued to experience an uncontrolled population growth putting a strain on the already scarce resources. It is projected that this trend will continue if nothing is done to avert this population explosion (2, 3). This rapid population growth, inter alia, exacerbates poverty by putting a strain on the already meagre resources in most developing countries. In addition, women are more exposed to pregnancy-related morbidity and mortality. There is already growing concern that this rapid population growth and increasing maternal mortality ratio is likely to hinder achievement of developmental and health goals in African countries.

Family planning is very important for any country for policy formulation and as one way of sustaining socio-economic development. However, uptake in Africa has remained very low with only 30% of the women using modern contraceptive methods (1, 4). Family planning was included in the fifth Millennium Development Goal (MDG) as one way of improving maternal health and potentially

reducing maternal mortality. However, as we get to the target year of the conclusion of the millennium goals, there is still so much that needs to be done beyond 2015 to increase contraceptive uptake among women in most African nations as we transit to the Sustainable Development Goals (SDGs) (5).

Kenya, like most of the African countries is grappling with a run-away population growth beyond the resources for the country and an increasing maternal mortality ratio (6, 7). Despite scaling up family planning services within the country, Utilisation has remained quite low with only about a third (39%) of married women using the contraceptives (6). This has contributed to the soaring population growth putting a strain on the already scarce resources. Further, lack of Utilisation of family planning has also been associated with unsafe abortions which subsequently contribute to an increase in maternal mortality rate in Kenya (8).

Previous studies (1, 2, 9) have shown some of the factors contributing to low family planning use include difficulty in getting family planning supplies, access to family planning clinics, lack of male involvement in family planning and the high value some of the African cultures place on large family size, among others. The 1994 International Conference on Population and Development (ICPD) in Cairo (10) provided a foundation for expanding family planning and reproductive health services to include men. The ICPD Programme

of Action states that “innovative programmes must be developed to make information, counselling, and services for reproductive health accessible to adolescents and adult men.”

Although the call to involve men was made in this conference, most of the global efforts on increasing family planning have continually targeted women and very little has been done to involve the male partner in reproductive health yet, they remain the central drivers of high fertility all over Africa. Men also play a key role in family planning decisions either through their direct participation or enabling their partners to use contraceptives. The failure to include men in family planning programmes has had serious implications in terms of curbing population growth. Current reports have also shown that the decision to use or not to use contraceptives and the choice of contraceptives among women in developing countries is largely dependent on the approval from their husbands (9, 11, 12). Consequently, men have an important role to play in the uptake of maternal health and family planning services due to the key decisions that they make in the family and/or relationships (13-16). In situations where men have been involved, improvements have been reported in the Utilisation of services by both men and women (14).

Although the current focus is on the actual mainstreaming of male services into maternal health services, studies on possible factors that influence men to participate in family planning remain scant. We, therefore, designed this study to establish factors that influence Utilisation of family planning among Kenyan men. This information is important for policy guidance on decisions to mainstream male friendly services in maternal health services in the country.

## MATERIALS AND METHODS

We analyzed data from the nationwide Kenya Demographic and Health Survey (KDHS) conducted in 2008-09. The KDHS provides a nationally representative sample of population estimates for the country as a whole, in both urban and rural areas in all the eight provinces. This data is freely available and easily accessible by the public from the Measure DHS Website (<http://www.measuredhs.com>) after registration. It utilises a two-stage stratified sampling design. In the first stage the sampling frame is gathered from the 1999 Population and Housing Census and stratified by region and urban-rural location. Clusters are then randomly selected from each stratum proportional to population size. The second stage involves random selection of households within the selected clusters.

**Description of dataset:** Our unit of analysis (case) in this study was the individual man aged 15-54 years. The men's recode file (KEMR52FL data set) was used. This dataset has a record for every eligible man between 15 years and 54 years of age who was interviewed. It contains all the data collected in the men's questionnaire including some salient variables from the household. We excluded 595 men who reported that they had never had sex. The final weighted sample size was 2937 men in the male recode file.

**Male participation in family planning:** A man is said to be participating in family planning if he is using a modern contraceptive method such as a condom or vasectomy or

for a female related modern family planning method, the decision for use was joint or male decision. The exclusion criterion was men who reported that they have never had sex.

**Independent variables:** Male perception (Contraception is women's business and a man should not have to worry about it; woman who uses contraceptive may become promiscuous), desire for more children, number of children, number of partners, discussion on FP with health worker last few months, socio-demographic factors such as education, employment, occupation, age, income, residence (rural or urban), marital status and religion.

**Dependent variable:** Family planning uptake.

**Data Analysis:** Data were analyzed using Stata 10 (StataCorp). Descriptive statistics are presented mainly as frequencies and percentages because most of our variables are categorical.

We fitted an unadjusted logistic regression model to assess whether there were any associations between the outcome variable (Utilisation of family planning services) and the socio-demographic characteristics of the respondent, male perception to family planning, and desire for more children. In our multivariate analysis we fitted an adjusted binary logistic regression model to assess the effect of male perception of family planning on the Utilisation of such services, while controlling for confounders - namely, province, place of residence, paternal characteristics (age, marital status, education, employment status, parity, desire for more children).

In all our analyses we used the “svy” set command in Stata to adjust for the complex sampling scheme used in the KDHS. We used the weights provided in the male dataset in the KDHS. All statistical testing was performed at 95 percent confidence level.

## RESULTS

This study was a further analysis of the 2008-2009 Kenya Demographic and Health Survey mainly focusing on factors associated with male Utilisation of modern family planning services.

**Factors associated with Utilisation of modern FP methods:** Descriptive statistics and univariate logistic regression results are shown for the two categories, namely household characteristics and male characteristics. The outcome variable is Utilisation of modern family planning method the year preceding the survey.

**Household characteristics:** This study found that in the eight provinces, the proportion of men who utilised a modern contraceptive method was highest (41.2%) among those living in Central, followed closely by Nairobi (39.7%), Nyanza (36.2%) and Rift Valley (36%). The univariate logistic regression showed men in the North Eastern province were significantly less likely to utilise a modern FP method compared to men in Nairobi. The odds of using a modern FP method were lowest (87% lower) among men in North Eastern province compared to those living in Nairobi (OR 0.126, CI: 0.062 - 0.255). After adjusting for other factors, men in Central were almost twice more likely to use an FP method compared to men in Nairobi (A.O.R 1.75, C.I. 1.112 - 2.759). Men in Nyanza were also almost twice more likely to use a family planning method than those in Nairobi (A.O.R 1.715, C.I. 1.100 - 2.673). Men in Rift Valley and those in Coast were one and a half times more likely to

use a family planning method than those in Nairobi (A.O.R 1.641, C.I 1.095 – 2.460) and (A.O.R 1.6, C.I 0.974 – 2.200).

Over one third, (37.4%) of men living in urban areas use modern FP methods compared to those living in rural areas. Men in the rural areas have 15% lower odds of utilising a modern FP method (OR 0.847, CI: 0.682 - 1.051) compared to those in the urban areas.

Slightly more than two fifths (40.3%) of those in the richest wealth quintile utilise a modern FP method as compared to those in the poorest wealth quintile (20.7%). The odds of a man utilising a modern FP method consistently decrease as one gets to the lower wealth quintiles. Men in the richest wealth quintile have higher odds of utilising a modern FP method than those who are poor (OR 2.588, C.I: 1.804 - 3.712).

Men with higher education had the highest (47%) Utilisation of FP methods compared to those with no education (12.6%). Men with the highest level of education (secondary or higher) had higher odds of using family planning (OR 6.150, C.I: 2.928-12.916) than their counterparts with no formal education.

The percentage of men using FP services is highest (41.1%) among men who are single than those who have more than one wife (17.5%). The odds of Utilisation of family planning services are much lower among men who

have more than one wife and highest among those with no wife or one wife (O.R 0.303, C.I: 0.174 - 0.527). Over one third, (37.2%) of men who had received information through the media had a higher odd of utilising FP (O.R 1.886, CI: 1.419 - 2.505). Men who had discussed family planning with a health care worker had higher odds of utilising FP services than those who had not (O.R 1.854, CI: 1.326 - 2.592). Almost two fifths (38.8%) of men who had a positive perception towards family planning had higher odds of utilising FP services than their counterparts who had a negative perception (O.R 1.426, C.I: 1.180 - 1.723) (Table 1).

From the adjusted odds ratio after controlling for other factors, we found; Religion (other) A.O.R 0.662 (C.I: 0.469 – 0.935), province (Central province) A.O.R 1.75 (C.I: 1.112 – 2.759), higher education A.O.R 1.923 (C.I: 0.894 - 4.138), media as the source of information A.O.R 1.478 (C.I: 1.095 - 1.994), discussion with a health worker A.O.R 1.755 (C.I: 1.233 – 2.499), number of wives (more than one wife) A.O.R 0.037 (C.I: 0.003-0.405), no more desire for children AOR 2.6, (C.I: 1.619 - 4.210), total number of children one has (1-4) A.O.R 1.975, (C.I 1.212 -3.219), richest wealth quintile A.O.R 2.255 (C.I: 1.404 - 3.622) and male perception of FP A.O.R 1.398 (C.I: 1.155 – 1.692) as the main factors that influence male participation in family planning (Table 2).

**Table 1**  
**Distribution of men utilising a modern family planning method by household and male characteristics and associated univariate odds ratios, KDHS 2008-09**

Variable	Number of men	Percentage using FP	Unadjusted Odds Ratio (95% CI)
Age in years			
15 – 24	893	40.8	1
25 – 34	930	33.5	0.730 (0.561 - 0.950)
35 – 44	649	31.8	0.676 (0.501 - 0.912)
45 – 54	465	29	0.592 (0.418 - 0.838)
Current marital status			
Never married	996	43.4	1
Currently married	1780	30.4	0.569 (0.448 - 0.724)
Formerly married	161	27	0.483 (0.299 - 0.780)
Religion			
Catholic	762	34.5	1
Protestant	1852	37.3	1.128 (0.903 - 1.408)
Other	322	19.7	0.466 (0.333 - 0.653)

Region			
Nairobi	307	36.2	1
Central	315	41.2	1.235 (0.902 - 1.690)
Coast	231	31.2	0.799 (0.568 - 1.124)
Eastern	451	29.1	0.724 (0.492 - 1.066)
Nyanza	470	39.7	1.160 (0.867 - 1.551)
Rift valley	806	36	0.992 (0.727 - 1.356)
Western	309	29.9	0.752 (0.497 - 1.139)
Northeastern	46	6.7	0.126 (0.062 - 0.255)
Highest Education level			
None			
Primary	129	12.6	1
Secondary	1471	31.8	3.227 (1.565 - 6.653)
Higher	1008	37.6	4.174 (2.043 - 8.527)
	328	47	6.150 (2.928 - 12.916)
Type of residence			
Urban	810	37.4	1
Rural	2126	33.6	0.847 (0.682 - 1.051)
Number of wives			
0	1156	41.1	1
1	1648	31.4	0.656 (0.518 - 0.832)
2	132	17.5	0.303 (0.174 - 0.527)
Employed currently			
Yes	2704	34.4	0.858 (0.605 - 1.216)
No	232	37.9	1
Wealth Index			
Poorest	404	20.7	1
Poorer	498	33.7	1.951 (1.291 - 2.947)
Middle	522	34.3	2.007 (1.388 - 2.902)
Richer	630	36.7	2.222 (1.528 - 3.230)
Richest	882	40.3	2.588 (1.804 - 3.712)
Source of information (Media)			
Yes			
No	2366	37.2	1.886 (1.419 - 2.505)
	571	23.9	1

Discussed FP with healthworker			
Yes			
No	333	47.7	1.854 (1.326 - 2.592)
	2604	33	1
Desire for more children			
2 years			
After 2 years	278	16.5	1
Undecided	504	29.7	2.148 (1.278 - 3.613)
No more/ Sterilized	140	19.3	1.215 (0.552 - 2.675)
NA	852	37.4	3.029 (1.955 - 4.694)
	1163	40.9	3.515 (2.282 - 5.415)
Total children ever born			
None			
1 to 4	1087	39.4	1
Above 4	1227	34.8	0.821 0.636 - 1.059)
	622	25.9	0.536 (0.397 - 0.724)
Male perception for FP			
Negative			
Positive	1536	30.8	1
	1400	38.8	1.426 (1.180 - 1.723)

**Table 2**  
**Factors influencing male participation in family planning (Adjusted Odds Ratio)**

Variable	Adjusted OR	(95%) C.I
Age in years		
15 – 24	1	
25 – 34	1.011	0.669 - 1.530
35 – 44	0.910	0.566 - 1.464
45 – 54	0.869	0.507 - 1.489
Religion		
Catholic	1	
Protestant	1.061	0.843 - 1.337
Other	0.662**	0.469 - 0.935

Region		
Nairobi	1	
Central	1.751**	1.112 - 2.759
Coast	1.464	0.974 - 2.200
Eastern	1.120	0.688 - 1.822
Nyanza	1.715**	1.100 - 2.673
Rift valley	1.641**	1.095 - 2.460
Western	1.238	0.757 - 2.024
Northeastern	0.617	0.259 - 1.473
Highest Education level		
None	1	
Primary	1.279	0.611 - 2.677
Secondary	1.376	0.643 - 2.943
Higher	1.923	0.894 - 4.138
Type of residence		
Urban	1	
Rural	1.002	0.690 - 1.453
Number of wives		
0	1	
1	0.063**	0.006 - 0.621
2	0.037**	0.003 - 0.405
Employed currently		
Yes	1.107	0.755 - 1.623
No	1	
Wealth Index		
Poorest	1	
Poorer	1.635**	1.073 - 2.491
Middle	1.655**	1.120 - 2.445
Richer	1.640**	1.097 - 2.452
Richest	2.255**	1.404 - 3.622
Source of information (Media)		
Yes	1.478**	1.095 - 1.994
No	1	
Discussed FP with health worker		
Yes	1.755**	1.233 - 2.499
No	1	

Desire for more children		
2 years	1	
After 2 years	1.789**	1.077 - 2.973
Undecided	1.027	0.413 - 2.554
No more/ Sterilized	2.611**	1.619 - 4.210
NA	0.404	0.042 - 3.849
Total children ever born		
None	1	
1 to 4	1.975**	1.212 - 3.219
Above 4	1.603	0.881 - 2.916
Male perception of FP		
Negative	1	
Positive	1.398**	1.155 - 1.692

*Key*

\* *The numbers marked with asterisk(s) means significant at 5% level of significance.*

## DISCUSSION

As we come to the conclusion of the target timeline for achievement of Millennium Development Goals transitioning into the SDGs, it is clear that the fifth goal has not yet been fully realised(5). Contraceptive uptake, which is one of the main indicators still remains low despite the fact that it has great benefits in reducing pregnancy related maternal deaths. Mainstreaming of male participation into maternal health/family planning services is among the strategies of increasing contraceptive uptake (14, 17). Pregnancy affects both partners and therefore, the decision about whether to use or not use contraception should be made by two individuals. Several factors influence male participation in family planning in Kenya.

Male perception towards family planning is a key factor that determines whether men utilise family planning services or not, or whether they support their spouses to use a method of family planning or not. In this study, men who had a positive perception towards use of family planning had higher odds of using family planning than those who had a negative perception. This is supported by various studies on male perception and maternal services uptake (13, 17-19). Studies have shown that counselling of men by health workers may help in changing their attitude towards family planning and therefore, increase their acceptance to use or support their spouses to use the family planning services (16, 20).

This study has shown that men with higher education are more likely to participate in family planning compared to those with no education at all. This finding is supported by a few studies (15, 21, 22) on men and use of reproductive health care. Educated men are more likely to be exposed to a lot of information on reproductive health through media or reading materials and books (23). The information has high potential to open up their mind and make them less conservative than their counterparts who do not have any

formal education.

Men who have access to media as a source of information have higher odds of participating in family planning compared to those who do not. This finding is supported by evidence from other studies (15, 19, 24). Media plays a major role in sensitising people on reproductive health issues. Communication regarding reproductive health issues for men is mainly done through mass media campaigns(24). Since the men often have more free time than women, they are able to access information from the media more frequently than the women(18). Men, therefore, need to be given correct information about contraceptives using such media fora in order to increase acceptability and uptake. In fact, some studies have shown increased acceptability and utilisation of family planning services among men when they receive information through various intervention projects that utilise the media for sensitisation (14).

Health related information is best relayed by the health workers themselves whenever they interact with their clients or patients on a daily basis. In this study, men who have had a discussion with a health worker have higher odds of participating in family planning services than those who have not had any contact with a health worker. Some studies (18, 19, 24), as already indicated, show that men mainly get reproductive health information through media. However, in some cases, those who attend health facilities are still able to get such information (23, 25). The health workers provide information through counselling services and, since they are trusted by society as the people who hold correct information about health, men access such information and possibly utilise it (22, 26). This study further presents the willingness for men to be given more reproductive health information. This presents a salient opportunity for health workers to ensure that there are no missed opportunities whenever they meet men in the health care system.

Men who have one wife have greater odds of participating in family planning compared to those who have many wives.

Other studies (27-30) have also shown similar findings. It is much easier for a man who has one wife to plan with his wife than when a man has multiple wives. In polygamous relationships, each of the women will be competing to get the man's attention by giving birth to as many children as possible and, therefore, family planning is not likely to feature.

The study also found that men who no longer had a desire for more children were more likely to participate in family planning. This finding is supported by evidence from recently published reports (15, 31, 32). Men are likely to have no more desire for children if they feel they already have the number of children that they are able to care for. Given the increasing cost of living, the more the children, the more the expenses and less money to spend in the family. Since the men are the main bread winners in most homes, they are likely to adopt a family planning method or influence their partners to do so when they begin to feel that they no longer need more children. However, in most African societies, this may be influenced by the sex of the children that they already have. There is a cultural preference for male children. Family planning programs can target to reduce the desire of men for more children in their various education programs.

Men in the wealthiest quintile are more than twice more likely to participate in family planning compared to their poor counterparts. These results are corroborated by other studies (26, 33, 34) that have also shown that richer men are more likely to utilise FP services. Rich men are likely to be educated and, therefore, understand the importance of family planning. A rich man also has the money power and, is therefore, able to purchase the family planning services much more easily than a poor man. Rich men are also more likely to be exposed to health related information through media such as TV and Radio.

Finally, our study also found that the total number of children one has influences the men on whether to use or not to use family planning methods. When a man has at least one child or more, they are more likely to utilise a FP method than a man who has no children. Other studies (15, 22, 31) have shown similar findings. In most African settings, fertility is viewed as very important especially when one is married. Marriages may break simply because a couple is unable to get children. It is for this reason that most people will delay use of contraception until they have had at least one child to prove their fertility status (31, 32).

In Conclusion, this study has shown several factors that influence male participation in utilisation of family planning services in Kenya. These factors include male perception of FP, higher education, employment, use of media, discussion with a health worker, number of wives and total number of children. The use of media and health workers needs to be emphasized as means of ensuring that men get the right information to make informed decisions to reduce missed opportunities.

Mainstreaming of male friendly services in maternal health needs to focus on addressing these factors in order to increase chances of the success of programs.

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