THE ROLE OF MEN IN REPRODUCTIVE HEALTH: An Examination of Determinants of Male Involvement in Family Planning in Kenya

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Abstract

Introduction: Reproductive Health and Family planning programs and services in Kenya normally focus at women. Services such as cervical cancer screening, antenatal and post-natal care, abortion and post abortion care, and maternal health among others are only offered to women. These programs and services have left out men not putting into consideration the responsibility they play in enhancing the uptake of family planning and reproductive health services[i].

Objectives: This study aimed to examine men's role in family planning in Kenya by investigating factors that influence their involvement in Family planning.

Methodology: The data source was a nationally representative 2014 Kenya Demographic and Health Survey (DHS) of men aged 15-54 years. The analysis was restricted to 6,693 (weighted) married men and those who were living together with partner. This age group of married men and those who are living together with partner were selected because they are sexually active and more likely to be involved in family planning. Chi-square tests and binary logistic regression analysis were applied to determine the relationship between various kinds of variables and the probability of male involvement in family planning and reproductive health.

Results: The study revealed that 44 percent of Kenyan men were involved in family planning. Findings from bivariate analysis indicated that husband's age, wife/partner's age, religion, husband's occupation, level of education, exposure to family planning messages, number of living children and knowledge on contraception were significantly associated with male involvement. Results of logistic regression showed that men who had higher education level, exposed to family planning messages, discussed family planning with health provider had high likelihood of being involved in family planning issues.

Conclusion: The level of male involvement in family planning in Kenya is still low despite interventions by both the government and other nongovernmental organizations. Therefore, more efforts should be made to improve education standards especially for men and to reorient family planning services to make them more accessible to men.

Introduction

Family planning (FP) refers to practices that help couples to attain certain objectives: avoid unintended pregnancies, control the time at which birth occurs and determine the number of children in the family[ii]. The practice enables couples to plan their families in accordance with their needs and resources[iii]. As the first pillar of safe motherhood and essential component of primary health care, family planning plays a major role in reducing maternal and newborn morbidity and mortality. Thus family planning is one of the most cost-effective ways of improving health and increasing quality of life. However, traditional beliefs, religious barriers and lack of male involvement have weakened family planning interventions[iv]. There are several studies available on family planning in developing countries but most of them have centred on women.

The roles and responsibilities of men in family planning and fertility regulations have been ignored, understudied and underutilized. Their views on sexuality, family size, birth spacing and similar topics have rarely been sought in fertility or family planning surveys. For example, in only seven percent of the 42 world fertility surveys conducted were husbands interviewed[v]. In Kenya, programme efforts to promote male participation in family planning and reproductive health have been minimal. A few projects such as; the Male as Partners project and Young Men as Equal Partners project that were implemented by Family Association of Kenya (FPAK), were in response to the 1994 ICPD PoA to enhance male involvement[vi]. The program of action adopted by the International Conference on Population and Development (ICPD) held in Cairo noted that special efforts ought to be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour[vii]. The Beijing world women conference in 1995 also re-enforced this message when it recognized the importance of "shared responsibility between men and women in all issues related to reproductive health". Therefore, promotion of male involvement in family planning and reproductive health will foster better relationship between men and women as equal partners in promoting the wellbeing of their families as well as help to achieve equity in gender relations and responsible sexual behaviours.

Family planning programmes should always be a concern for both the man and the woman. Historically though, most of the family planning programs have been a woman affair. Many studies have also indicated that family planning programs in many African societies unsuccessful because they fail to take into account the power relations between couples and patriarchal nature of the societies[viii]. This is also true for Kenyan families where the organization of the society is governed by the characteristically male dominant and patrilineal traditions.

Excluding men in family planning programmes can be attributed to poor family planning and reproductive health indicators experienced in most countries , for instance unmet need for family planning in Kenya was recorded at 18 percent as reported in the 2014 KDHS. Although recent findings show an increase in the contraceptive prevalence rate from 46 percent in 2008, to 58 percent in 2014, the total fertility rate is still high and has stagnated for a decade (4.6 in 1998, 4.7 in 2009) until recently when it slightly dropped to 3.9 in 2014. Despite the continued commitment by the government to the promotion and provision of family planning and reproductive health services, low male involvement is one of the key compounding factors that impede the demand for and utilization of family planning and reproductive health services. One of the identified key challenges facing these programmes is the relatively low level of male involvement in family planning and reproductive health. This is despite the fact that the policy framework (Reproductive Health Policy and Population Policy for National Development) in Kenya provides for greater involvement of men in family planning and reproductive health programmes. Therefore, for Kenya to effectively promote male involvement in family planning and reproductive health, there is need to understand and address the contextual issues behind the low male involvement. For purpose of this study, male involvement is not only restricted to the uptake of family planning methods but also includes number of men who encourage and support their partners and peers to use family planning. Thus male involvement should be understood as all organizational activities whose main aim is to increase the prevalence of contraceptives for either gender[ix]. This study therefore seeks to understand the determinants of male involvement in family planning in Kenya among married men, by exploring factors (explanatory variables) that are correlated with male involvement in family planning (outcome variable). The findings from this study will be of significant importance not only to the Government of Kenya, but also to partner organizations working on family planning in Kenya to inform programs that influence contraceptive use decisions among men and women. Policy makers will also find it beneficial in formulation of policies in the family planning programs to guide fertility behaviour of both men and women.

Methods

Sources of Data

This study used data from nationally representative 2014 Kenya Demographic and Health Survey (DHS) of married men aged 15-54 years.

The survey was designed to provide population and health indicator estimates at the national, provincial and county level. The data was sourced from Measure DHS website, after obtaining approval for use of the data. The data downloaded was man's recode file that contained information about all men interviewed in 2014 KDHS.

Kenya Demographic and Health Survey applied probability sampling to provide nationally representative samples of men aged 15–54 years. The survey was conducted by the Kenya National Bureau of Statistics and Inner City Fund (ICF) International. Interviews with men covered 12,819 of the eligible 14,217 men, yielding a response rate of 90 percent. Data was weighted in order to adjust for differences in probability of selection and to adjust for non-response. This is the latest DHS survey data available for Kenya. This analysis therefore, was restricted to 6,693 (weighted) men. These included married men (6,439) and those who are living together with partner (254) aged 15-54 years. This age group of married men and those who are living together with partner were selected because they are sexually active and more likely to be involved in family planning.

Study Variables

The dependent variable in this study is male involvement in family planning. This variable was measured using a composite of five questions coded yes=1, no=0, related to reproductive health and family planning adoption from the 2014 KDHS. These questions included the following;

i. Have you used any contraceptive method (condom, safe period/periodic abstinence and withdrawal, male sterilization and other male method)?
ii. Were you present during check-ups for most recent child?
iii. Would you like to have another child?
iv. Is contraception a woman's business and men should not worry about it?
v. Do women who use contraception become promiscuous?

The questions used to construct Scores for each question were summed and dichotomized (low involvement =0-2, high involvement=3-5).

The independent variables were grouped into categories hypothesized to influence male involvement in family planning. The pre-disposing factors (age, religion, occupation, level of education, place of residence) and enabling factors (exposure to family planning messages, discussed family planning with health provider, number of living children, and knowledge of contraception) are hypothesized to influence male involvement in family planning.

Data analysis

A statistical package for social scientists (SPSS) version 22 was used to conduct data analysis. Descriptive statistics was used to provide sample characteristics of respondents including; Age distribution, religion, occupation, level of education, place of residence, number of living children, knowledge on contraception and exposure to family planning messages. Secondly, bivariate analysis was carried out between each predisposing and enabling variables using cross tabulation and chi-square test statistic to determine statistical association between the dependent and independent variable. Independent variables that were significantly associated with the dependent variable at 5% level of significance or less, were included in the binary logistic regression analysis to further asses how each variable influences male involvement in family planning. Binary logistic regression analysis was used since the outcome variable (male involvement) was dichotomous and coded as 1-High involvement and 0- low involvement. All analyses were weighted to account for differences in sampling probabilities.

Results

Sample description

Table 1 and 2 presents the description of six thousand six hundred and ninety three (6,693) married men aged 15-54 years from Kenya who participated in the 2014 Kenya Demographic and Health Survey.

Table 1: Percentage distribution of sample population characteristics by pre-disposing factors

CHARACTERISTIC	PERCENT (%)	NUMBER (N=6,693)
Husbands Age		
15 - 24	5.9	395
25 - 34	36.7	2,453
35 - 44	34.9	2,335
45 - 54	22.6	1,510
Wife's/Partners Age		
<25	28.5	1,909
26 - 34	39	2,608
35 - 44	25.1	1,680
45+	7.4	496
Religion		
No Religion	4.2	282
Roman Catholic	21.8	1,462
Protestants	62.5	4,182
Muslim	11.5	767
Occupation		
Not working	1.3	84
Professional & Clerical	16.2	1,086
Sales & Services	6.1	407
Agriculture	46.8	3,131
Skilled & Unskilled	29.7	1,985
Husbands level of Education		
No Education	8.6	575
Primary	51.4	3,438
Secondary & Higher	40	2,689
Residence		
Urban	39.9	2,672
Rural	60.1	4,021

Source: Analysis of 2014 KDHS Data

Majority of the respondents were between ages 25-34 years old (36.7%), followed by ages 35-44 (34.9%). Those between ages 45-54 years old comprised 22.6 percent and only 5.9 percent of the respondents were between ages 15-24. Among the sample population of married men analysed in this study, thirty nine percent (39%) were married to women aged between 26-34 years. Approximately twenty nine percent (28.8%) were married to women below 25 years of age, while twenty five percent (25.1%) were married to women between ages 35-44 years. A small proportion of men (7.4%) got married to women above forty five years.

With regard to religion, approximately six out of ten men were Protestants (62.5%), while slightly above one fifth (21.8%) were of Roman Catholic faith and about one out of ten (11.5%) were Muslims.

A large proportion of men (98%) were engaged in an income generating activity in the 12 months prior to the survey, with forty seven percent (46.7%) engaging in agriculture, thirty percent (29.7%) in skilled/unskilled activities, sixteen percent (16.2%) were professionals or clericals and only one percent (1.3%) with no occupation. Nearly all respondents had attended school, with slightly more than half (51.4%) having attained primary education whereas forty percent (40%) had secondary and higher.

About four out of ten men (39.9%) resided in urban areas while six out of ten (60.1%) resided in rural areas.

Table 2: Percentage Distribution of sample population characteristics by enabling factors

CHARACTERISTIC	PERCENT (%)	NUMBER (N=6,693)
Exposure to FP Messages		
(i) Heard on Radio FP messages		
No	17.7	1184
Yes	82.3	5,509
(ii) Saw on TV FP messages		
No	45.2	3,022
Yes	54.8	3,671
(iii) Read on Newspaper FP messages		
No	58.3	39,05
Yes	41.7	2,788
Discussed FP with Health Provider		
No	84.2	5,633
Yes	15.8	1,060
Knowledge on Contraception		
Knows No Method	0.9	59
Knows Only Traditional	0.1	6
Knows Modern Methods	99	6,628
Number of Living Children		
None	4.9	331
1 - 2 Children	35	2,343
3 Children and above	60	4,019

Source: Analysis of 2014 KDHS Data

Responses on exposure to family planning messages showed that a vast majority of men get information on family planning through the radio (82.3%), slightly above half (54.8%) watched family planning messages on television, and forty two percent read in a newspaper. Six out of ten men had three children and above (60%) while only five percent (4.9%) had no children. Nearly all men know modern contraceptive methods (99%) while only one percent (0.9%) knows traditional method. However, only a small proportion (15.8%) had discussed family planning issues with health worker.

Level of male involvement in family planning

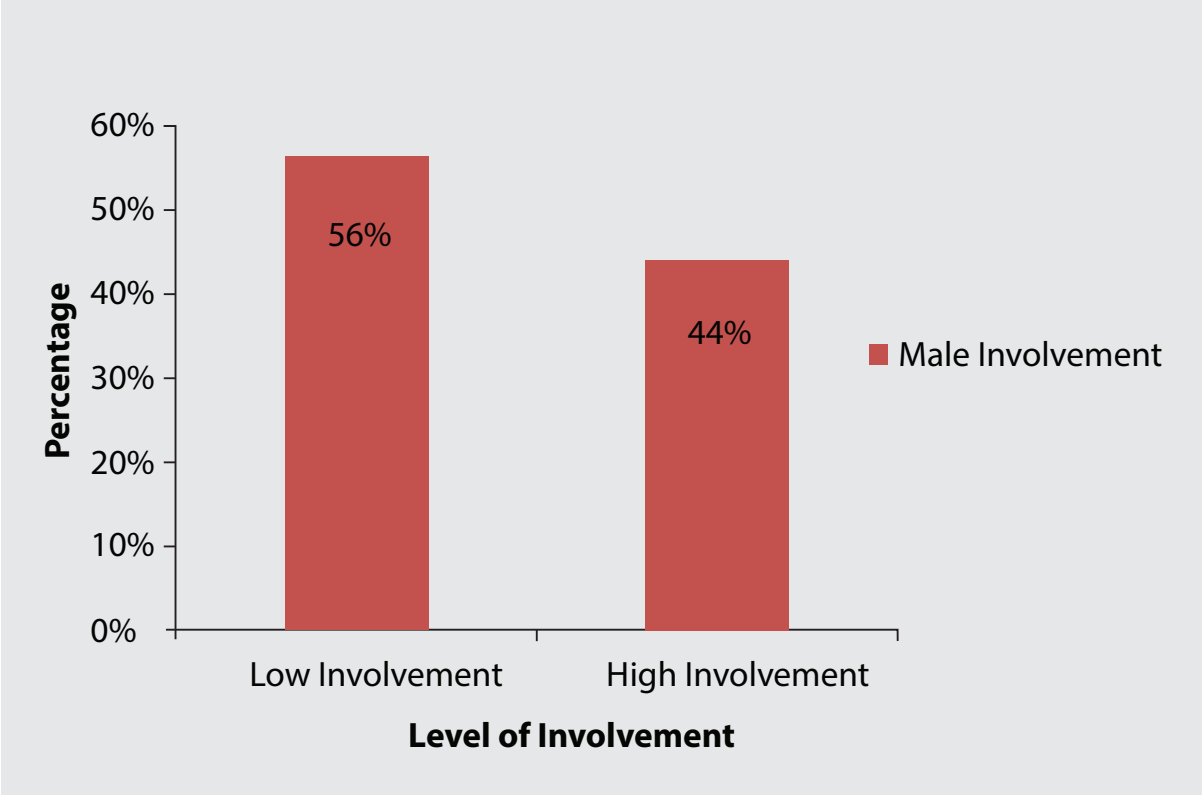

Figure1: Percentage level of male involvement in FP in Kenya, 2014

Overall, fifty six percent (56%) of men in Kenya were not involved in family planning. Only forty four percent (44%) were involved in family planning and reproductive health issues.

Pre-disposing factors and male involvement

Table 3: Relationship between pre-disposing factors and male involvement in family planning

Variable	Male Involvement				Total
	Low		High		
	N	%	N	%	N(6,693)
Husbands Age					
15-24	359	90.9	36	9.1	395
25-34	1,761	71.8	692	28.2	2,453
35-44	1,150	49.3	1,185	50.7	2,335
45 and Above	476	31.5	1,034	68.5	1,510
χ^2 **=853.493, df=3 , P-value=0.000**					
Wife's/Partners Age					
<25	1553	81.4	356	18.6	1,909
26-34	1493	57.2	1,115	42.8	2,608
35-44	581	34.6	1,099	65.4	1,680
45+	119	24	377	76	496
χ^2 **=1,018.390 , df= 3 , P-value=0.000**					
Religion					
No Religion	190	67.4	92	32.6	282
Roman Catholic	763	52.2	699	47.8	1,462
Protestant	2,161	51.7	2,021	48.3	4,182
Muslim	632	82.4	135	17.6	767
χ^2 **= 272.085, df=3 , P-value=0.000**					
Occupation					
Not Working	63	75	21	25	84
Professional & Clerical	544	50.1	542	49.9	1,086
Sales and Services	236	58	171	42	407
Agriculture	1,754	56	1,377	44	3,131
Skilled and unskilled	1,149	57.9	836	42.1	1,985
χ^2 **= 31.194 df= 4 , P-value=0.000**					
Husbands Level of Education					
No Education	503	87.5	72	12.5	575
Primary	1,958	57	1,480	43	3,438
Secondary and Higher	1,285	47.9	1,395	52.1	2,680
χ^2 **=302.970 df= 2 , P-value=0.000**					
Residence					
Urban	1,530	57.3	1,142	42.7	2,672
Rural	2,216	55.1	1,805	44.9	4,021
χ^2 **= 3.011 df= 1 , P-value=0.083**					

Source: Analysis of 2014 KDHS data

In relation to predisposing factors that influence male involvement in family planning, husband's age, wife/partner's age, religion, husband's occupation, and level of education were found to be strongly associated with male involvement. However, there was no significant relationship between place of residence and male involvement (p-value>0.05). About nine percent (9.1%) of men aged 15-24 years were involved in family planning, half (50.7%) aged 35-44 participated in family planning and 68.5 percent aged above forty five years were involved in family planning. This indicates that male involvement in family planning and reproductive health increases with an increase in age. Similarly, findings from this study revealed that men whose wives/partners were aged 25 yrs

and above highly participated in family planning compared with men whose wives/partners were below 25 years of age.

With regard to religion, findings showed slight difference in male involvement in family planning among men who profess catholic faith (47.8%) and the Protestants (48.3). This can be attributed to the fact that practitioners of a faith do not necessarily adhere to the prescribed doctrines of their faith. In contrary, Muslim men (17.6%) were not actively involved on family planning issues an indication that Muslim men adhere strictly to their doctrine which prohibit use of family planning especially sterilization as posited by Ringheim in his study on factors that determine prevalence of use of contraceptive methods for men[x].

Male involvement in family planning was higher among professionals and clericals (49.9%), followed by those engaged in agricultural activities (44%), those in sales/service industry were 42 percent. This is an indication that the higher the occupational status, the greater the involvement of men in family planning. In terms of education level, male involvement increased with husband's education level. Those men with secondary education and higher were highly involved in family planning compared with those who had no education and primary education respectively.

On the contrary, place of residence was found to be insignificant with male involvement in family planning. The findings show slight difference in male involvement among urban (42.7%) and rural (44.9%) men. This is an indication that both rural and urban men have access to family planning services in Kenya, and this can be as a result of the work of community health workers at the community level.

Enabling Factors and male involvement in family planning

Table 4: Relationship between enabling factors and male involvement in family planning

Variable	Male Involvement				Total N(6,693)
	Low		High		
	N	%	N	%	
Exposure to FP Messages					
(i) Heard on Radio FP Messages					
No	858	72.5	326	27.5	1,184
Yes	2,888	52.4	2,621	47.6	5,509
χ^2 **=158.862, df=1, P-value=0.000**					
(ii) Saw on TV FP Messages					
No	1,888	62.5	1,134	37.5	3,022
Yes	1,858	50.6	1,813	49.4	3,671
χ^2 **=94.643, df=1, P-value=0.000**					
(iii) Read on Newspaper FP Messages					
No	2,401	61.5	1,504	38.5	3,905
Yes	1,345	48.2	1,443	51.8	2,788
χ^2 **= 115.757, df=1 , P-value=0.000**					
Discussed FP with Health Provider					
No	3,217	57.1	2,416	42.9	5,633
Yes	529	49.9	531	50.1	1,060
χ^2 **= 18.789 df= 1 , P-value=0.000**					
Number of Living Children					
None	306	92.4	25	7.6	331
1-2 children	1,712	73.1	631	26.9	2,343
3 children & above	1,728	43	2,291	57	4,019
χ^2 **= 731.203 , df=2 , P-value=0.000**					
Knowledge on Contraception					
Knows No Method	59	100	0	0	59
Knows Only Traditional	6	100	0	0	6
Knows Modern Methods	3,681	55.5	2,947	44.5	6,628
χ^2 **= 51.637 df= 2 , P-value=0.000**					

Source: Analysis of 2014 KDHS data

The results showed a strong significant relationship between exposure to family planning messages, interaction with health provider, number of living children, knowledge on contraception and male involvement. The findings indicated that men who were exposed to family planning messages through the radio, TV and reading newspaper were more likely to be involved in family planning than those who were not exposed (p-value<0.05). The analysis further showed that interaction with health provider (having discussed FP with health provider) increases the likelihood of male involvement in family planning. The findings indicate that half of men (50.1%) who discussed family planning issues with health provider were highly involved in family planning compared to their counterparts who did not discuss family planning with health provider (42.9%). On the other hand, this study also revealed that number of living children influence male involvement in family planning. Men with higher number of children (three and above) were highly involved in family planning than those with none or one child. That is the more the number of children the higher the likelihood of men being involved in family planning.

Knowledge on family planning is a prerequisite to its use. The findings showed that knowledge on family planning methods among men in Kenya is universal especially modern contraceptive methods. Though the results showed a significant relationship between contraceptive knowledge and male involvement, their involvement in family planning was low (44.5%) despite high knowledge on modern contraceptives.

Multivariate Analysis results

Table 5: Logistic regression coefficients of male involvement in family planning

Variables	B	S.E	Exp(B)	95% CI for Exp(B)	
				Lower	Upper
Predisposing factors					
Husbands Age					
15-24 (ref)					
25-34	0.562	0.192	1.755***	1.204	2.558
35-44	0.837	0.203	2.308***	1.549	3.439
45 and Above	1.173	0.219	3.232***	2.106	4.960
Wife's/Partners Age					
<25 (ref)					
26-34	0.580	0.085	1.786***	1.513	2.108
35-44	1.131	0.110	3.099***	2.498	3.843
45+	1.471	0.163	4.354***	3.161	5.999
Religion					
No Religion (ref)					
Roman Catholic	0.333	0.160	1.394**	1.019	1.908
Protestant	0.345	0.153	1.412**	1.047	1.906
Muslim	-0.838	0.182	0.432***	0.303	0.617
Occupation					
Not Working (ref)					
Professional & Clerical	1.007	.306	2.736***	1.501	4.989
Variables	**B**	**S.E**	**Exp(B)**	**95% CI for Exp(B)**	
				Lower	**Upper**
Sales and Services	1.085	.320	2.958***	1.580	5.536
Agriculture	1.018	.299	2.767***	1.539	4.974
Skilled and unskilled	1.083	.302	2.952***	1.634	5.332
Husbands Level of Education					
No Education (ref)					
Primary	1.329	0.148	3.776***	2.827	5.044
Secondary and Higher	1.734	0.156	5.664***	4.168	7.697

Enabling Factors					
Exposure to FP Messages					
(i) Heard on Radio FP messages					
No (ref)					
Yes	0.364	0.089	1.439***	1.210	1.712
(ii) Saw on TV FP messages					
No (ref)					
Yes	0.193	0.070	1.213**	1.057	1.393
(iii) Read on Newspaper FP Messages					
No (ref)					
Yes	0.049	0.071	1.051*	0.914	1.207
Discussed FP with Health Provider					
No (ref)					
Yes	0.040	0.079	1.041*	0.891	1.216
Number of Living Children					
None (ref)					
1-2 children	1.139	0.222	3.123***	2.023	4.823
3 children & above	2.148	0.224	8.564***	5.526	13.272

Source: Analysis of 2014 KDHS data

Note: Ref=Reference category; ***P<0.01; **P<0.05; *P>0.10

Hosmer and Lemeshow goodness-of-fit χ^2 =19.953; df=8; P=0.011

Predisposing factors and male involvement in family planning

Logistic regression analysis shows that pre-disposing factors that explain most of the variations in male involvement in family planning in Kenya are husband's age, wife/partner's age, religion, occupation, and education level. Couple's whose husbands were aged between 25-34, 35-44, and 45 years and above, were 1.76, 2.31, and 3.23 times more likely to be involved in family planning than those aged 15-24. Similarly, couples whose wife's/partner's were aged between 26-34, 35-44, and 45 years and above were 1.79, 3.19, and 4.35 more likely to participate in family planning than those whose wife's/partners were below age 25. In general, the odds ratio increases with increasing age of respondent, probably reflecting an increase in men's participation in family planning as couples become older.

Religion is a powerful tool with the capability of swaying people's opinions as regards family planning. For instance, procreation is the primary purpose of marriages and sexual intercourse for Catholics[xi]. As such, the use of contraceptives violates the principal purpose of marriage. Results of this study indicate that the likelihood of Catholic (1.39 times) and Muslim (0.43 times) men participating in family planning are low compared with those with no religion which was used as reference category. On the other hand, protestant men are 1.41 times more likely to be involved in family planning than those with no religion. This result agrees with Lopresti argument that "mainstream conservative Protestants believe that marriages should be procreative; there are no prohibitions against using contraception within a marriage that already has children"[xii].

Analysis from this study indicates that man's occupation determines the extent of involvement in family planning. Men who are professionals/clericals, engaged in sales and services, agriculture, skilled and unskilled are 2.74, 2.96, 2.77, and 2.95 times more likely to participate in family planning respectively than those who are not actively engaged in any activity. Interestingly, professional/clerical men were less likely to participate in family planning compared with other men who are engaged in informal activities. This can be attributed to the fact that men who are engaged in informal sectors such as sales/services, skilled/unskilled artisans, and farming work full time thus consider children as a liability hence approve use of family planning by their wives.

Results show that husband's education level is the strongest predictor of male involvement in Kenya. In 2014, men with primary education were 3.78 times more likely to be involved in family planning than those men with no education. Similarly, men with secondary education and higher were 5.66

times more likely to participate in family planning than those with no education.

Enabling factors and male involvement in family planning

Findings indicate that exposure to family planning messages through radio and TV, and number of living children are strongly significant with male involvement in family planning. Interaction with health provider and access of family planning messages through newspaper were not significant though they influence male involvement in family planning. With regard to exposure to family planning messages, analysis indicates that men who access family planning messages through radio, TV, and newspaper are 1.43, 1.21, and 1.05 times more likely to be involved in family planning than those who are not exposed to family planning messages. As expected, interaction with health provider influences male involvement in family planning. Results indicate
that men who discussed about family planning with health provider are 1.04 times more likely to be involved in family planning than those who did not discuss family planning with health provider.
The analysis also suggests that number of living children influences male involvement in family planning in Kenya. In 2014, men with 1 to 2 children were 3.1 times more likely to be engaged in family planning than those with no children. Similarly, men with three or more children were 8.56 times more likely to be involved in family planning compared with those with no children. The odds ratio increases with an increasing number of children indicating that male involvement in family planning increases with parity.

Discussion

This study examined factors that are considered as the determinants of male involvement in family planning in Kenya among married men aged 15-54 years using the 2014 Kenya Demographic and Health Survey. The findings from bivariate analysis to an extent conformed to general literature on male involvement. In line with these studies, the bivariate analysis found that a number of predisposing and enabling factors are associated with male involvement in family planning.
These factors include; husband's age, Wife's/ partner's age, religion, occupation, level of education, exposure to family planning messages, discussion of family planning issues with health provider, number of living children and knowledge on contraception. However, place of residence was found to be insignificant with male involvement in family planning. Results at bivariate level indicate that men who reside in rural areas (44.9%) are more involved in family planning than urban men (42.7%). This may be attributed to the development of policies and programs that support task shifting and sharing of health service provision with Community Health Workers (CHWs) in Kenya, including provision of family planning services in rural areas. For instance, the establishment of the Community Strategy during the implementation of Strategic Plan II 2005–2010, whose objective was to provide health care services for all life cohorts and socioeconomic groups at household and community level[xiii]. The community strategy places the CHWs as the first level of health care providers. Their main activities include health promotion, disease prevention and provision of basic health care services including Family Planning in the community. Further, policy support for improving access to family planning was realized with the development of the National Reproductive Health Strategy (2009 - 2015) with an overall thrust of involving the
communities in reversing the decline in the health status of Kenyans through initiation and implementation of life cycle focused health actions at community level. The strategy aims at increasing coverage of reproductive health services including family planning, through changing attitudes and behaviours of families and individuals around reproductive health issues.

Multivariate analysis identified age, religion, occupation, level of education, exposure to family planning messages, interaction with health provider, and number of living children as the most important predictors of male involvement in family planning in Kenya. Results from this study demonstrated a significant relationship between age of respondent and male involvement, that is male involvement increases with age of respondent. The low male involvement among men aged 15-24 years may be due to the fact that most of these are newly married, and marriage is looked upon as an institution of producing children. However, this finding is in contrast with findings of Green and Chens on male involvement in reproductive health in Indonesia which did not find any association between age of the respondents and involvement

in family planning and other reproductive health services[ix].

Religious beliefs and faiths are powerful influences on individuals and communities worldwide and can affect behaviors, including health practices. Overall, religion was found to be consistently significant factor associated with male involvement in family planning in Kenya after controlling for different factors in the logistic regression. Muslim men were found to be less likely to be involved in family planning issues compared with men from other denominations. This finding echoes similar findings from the Kenya DHS which showed the influence of religion on contraceptive use. In 2014 DHS, lowest level of family planning use was recorded in the North Eastern province at 4 percent (North Eastern province is predominantly Muslim) compared with other provinces. Factors underlying high fertility rates are linked to poor socio-economic indicators in the region, more so, religion as well as adherence to various cultural practices which have been noted to undermine family planning programs in the region.

Men occupational statuses are found in this study to be very important factor for male involvement in family planning and reproductive health. In Kenya, professional/clerical working men sometimes enjoy autonomy in taking decision of their reproductive health and family planning and most of the time they take joint decision with their wives/partners about reproductive health. These findings are consistent with the findings of a study in Mpigi District, Uganda[xiv], on male participation in family planning which found out that male who had regular salaried jobs were highly involved in family planning, and that stable source of income increased access and bargaining power for services including healthcare.

This study also reveals that those couples with sound educational background keep a live discussion about family planning and reproductive health with each other, i.e. their husbands are more likely to be involved in family planning and reproductive health than their counterparts with no education. This indicates that raising the level of education is one effective strategy of promoting contraceptive use in Kenya. These findings corresponded to a similar study in Ghana, which revealed that the level of men's education influences a couple's overall fertility preferences[xv].

Importantly, findings from this study draw attention to the influence of exposure to family planning messages with male involvement in family planning. Communication of information and education on family planning (FP) to the currently married women and men is an important step to motivate them to practice contraception. Findings from this study showed that men who are exposed to family planning messages through radio, TV and newspaper are more likely to be involved in family planning than those who are not exposed.

Interestingly, results presented illuminate the critical role of interpersonal communication, and particularly discussion of FP issues involving men and health workers in effecting behaviour change. Male respondents who had discussed family planning with health workers were more likely to participate in family planning than those who had not. Discussion of family planning with health workers improves client's knowledge of contraception and therefore, contributes to beneficial behaviour change. Behaviour change models stipulate that knowledge is a primary step toward achieving behaviour change[xvi]. This finding is in agreement with findings from a study conducted in Congo where current use of modern contraception was correlated with having discussed contraception with a health worker[xvii]. Number of living children was found to be strongly associated with male involvement in family planning. Men as the decision makers in most marital and family matters may consider using family planning after they have already achieved their ideal number and sex composition of children. Men who have three and more current living children, have high probability to not only use of contraceptives by themselves but also give suitable support to their partner's contraceptive choice and reproductive health. These findingsechoes with Agadjanian study on gender, communication, and contraception in Urban Mozambique which found out those men with many children would be highly involved in family planning[xviii].

Recommendations

Policy recommendations

- Policies on family planning and reproductive health should be tailored to each county's unique situation.

- There is need to review the national family planning policies to ensure male services are integrated into existing ones in order to increase male involvement in family planning and use of male methods.

Programme recommendations

- There is need for government, development partners, NGOs and stakeholders to;
- Use innovative FP communication approaches targeting men involvement in FP/RH particularly in areas where cultural and religious practices are prevalent.
- Use mass media to disseminate adequate information on FP methods particularly the less popular methods and incorporate health messages to encourage positive attitudes towards reproductive health.
- Promote education and increase the educational status of male individuals and the community as a whole.
- Give great attention on young people and young adults to enable them to have a joint decision on family planning between the husband and wife to increase involvement of males on family planning.

Research recommendations

Qualitative research should be carried out to look for answers to these questions:

i.) What are the factors for further acceptance of family-planning programs by men?
ii.) What is men's role in fertility decision making?
iii.) How do couples reach consensus on the choice and use of a contraceptive method?
iv.) What are the determining factors for the acceptance or refusal by a woman to involve her partner in her reproductive health decision?

Limitations of study

First, the use of the DHS data limited the researcher to specific variables captured in the DHS dataset leaving out important factors that influence male involvement in family planning. For instance, spousal communication, approval of family planning was not captured in the 2014 Kenya Demographic and Health Survey yet past literature indicate that they are strong predictors of male involvement. Second, there were missing values in the dataset in some variables used in analysis and the author was not able to control such missing numbers in the dataset. This information would have further enriched analyses. However, despite these limitations, the paper provides an interesting contribution to the debate on male involvement in family planning, which has been a neglected issue for some time in Kenya.

Conclusion

The study concludes that the level of male involvement in family planning in Kenya is still low despite interventions both by the government and by other nongovernmental organizations in trying to increase the prevalence of family planning. Out of the six thousand six hundred and ninety three (6,693) married men studied in this study, only 44 percent were involved in family planning and reproductive health issues. Despite displaying high levels of knowledge on modern family planning methods available for both men and women, this did not result in high involvement in family planning. To enhance the level of male involvement in family planning issues in Kenya, accurate and adequate information should be disseminated mostly through audio-visual sources (radio and television) as they were found to be the most significant factors of male involvement and also common sources of information for men as indicated in 2014 DHS report. Therefore family planning service providers should strive to use mass media to disseminate adequate information about family planning through innovative FP communication approaches. Emphasis should be placed on use of FP and good birth spacing as efforts of promoting health for individuals and the community targeting men involvement in FP/RH particularly in areas where cultural and religious practices are prevalent.
In general, factors that can influence the degree of male participation in family planning can vary according to predisposing and enabling factors. Based on a nationally representative data from 2014 KDHS, this study concludes that predisposing factors (Husbands age, Wife's/partners age, religion, occupation, level of education and enabling factors (exposure to family planning messages, communicating with health provider about FP, number of living children, knowledge on contraception), play important roles in male involvement in Kenya. Programmers should pay special attention to organizing health education campaigns through engaging CHWs targeting men

to address the knowledge and information gap among men in FP/RH by educating and sensitizing them on importance of FP/RH services to address their health concerns and demystify myths and misconception about FP.

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