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RESEARCH ARTICLE

**MALE INVOLVEMENT IN FAMILY PLANING AT COUNTY REFERAL HOSPITAL KAKAMEGA,
 KENYA.**

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Abstract

Introduction: Male involvement in family planning is one of the strategies that were embraced in the International Conference on Population and Development meeting held in Cairo 1994 to help reduce the increasing population in Africa and elsewhere in the world. This study will investigate the common methods of family planning used currently; knowledge practice and attitude of men toward the use of the family planning methods, and the factors that hinder or encourage men to get involved family planning and hence determine family size.

Main objective: The main aim of this study is to determine the factors affecting male involvement in family planning in Sichilayi sub location.

Hypothesis: There is a relationship between knowledge level of family planning and uptake by men in Sichirai sub-location

Methodology: This study adopted the cross sectional research design. Snowball non-probability sampling technique was used in this study. Few respondents from Sichirayi sub-location were identified in Kakamega town, and then they were requested to provide information that will help the data collectors identify more respondents within the town.

Data analysis: Quantitative data was analyzed using SPSS. Descriptive statistic was used to compute chi square for contingency tables and inferences for chi square test will be based on p-value. Statistical significance will be considered when the p value will be below or equal to 0.05. Focused group discussion responses will be grouped into themes then analyzed.

Results: The study found high prevalence of knowledge of contraceptive methods among married men, low utilization of male methods of family planning. Men's attitude about FP was also found to be good since most of the men were of the idea that they have a role in FP. This was the opposite of the result of another study done in Bangladesh in 2011 that found very poor attitude of men towards use of FP.

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Abbreviations:-

FP	Family Planning
KDHS	Kenya Demographic Health Survey
TFR	Total Fertility Rate
ICPD	International Conference on Population and Development
IUCD	Intrauterine contraceptive device
NFP	Natural Family Planning
LAM	Lactation Amenorrhea Method
Cu- IUCD	Copper IUCD
COC	Combined Oral contraceptive
BTL	Bilateral Tubal Ligation
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Disease

Chapter one

Introduction:-

Worldwide population growth has declined from its historic peak of 2.1% per year in the late 1960s to 1.7% today (Tolassa, 2004). Population growth in most developed nation has declined drastically due to increased shared responsibilities in family planning (FP) between men and women. This is successful due to increased programs that encourage male involvement in FP. However sub Saharan Africa still faces the highest fertility and population growth rate in the world (Sichona et al 2000). The total fertility rate of sub-Saharan Africa stands at 4.9 children per woman (Rosenberg, 2009). This increased fertility rate in Africa is majorly contributed by lack of men involvement in family planning, given their role in decision making in almost all African societies (Francis J, 2008).

In Kenya, according to the (Kenya Demographic Health Survey) KDHS (2008-2009), the total fertility rate was 4.6 children per woman for the three years before the survey compared with TFR of 4.9 children reported for the period 2000-2002 based on 2003 KDHS. Little has been done to encourage males in Kenya to bear the responsibility of family planning to help reduce the growing population (Kenya G. o., National Family Planning Guidelines For service providers, 2010).

The concept of male involvement in FP is broad in nature. Male involvement in FP basically means more than increasing the number of men using condoms and vasectomy; male involvement also include the number of men who encourage and support their partners and peers to use FP and who influence the policy environment to be more conducive to develop male related programs. In this context male involvement should be understood in a much broader sense than male contraception and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family planning practice of either sex. The program of action adopted by the international conference on population and development (ICPD) held in Cairo 1994 notes that special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, maternal and child health, prevention of STDs, prevention of unwanted high risk pregnancy's and family planning program

Men represents about half of the world's population, (Ndenzako, 2008) and use less than one third of contraceptives, which are male methods or methods that require participation of both partners (Ringheim, 1996). The adaptation and correct use of female methods have been found to be positively effective by male involvement in family planning. Moreover men are more interested in reproductive health information than has been assumed (Ndezako, 2008) (Onyango, Owoko, & Oguttu., 2010). Other compelling reasons for involving men in FP are that millions of pregnancies are unwanted each year due to lack of or failure of contraception and thousands of women die due to pregnancy complications where male involvement can make a difference (UNFPA, 2008).

Chapter two:-**Literature review:-**

This chapter looks at the factors affecting male involvement in FP, common methods of family planning, and the knowledge attitude and practice of men on family planning.

A. 2.1 Factors limiting male involvement in family planning

Although men have some knowledge of family planning methods, approve family planning, and there is international advocacy of male involvement in family planning, there are a number of factors which have prevented men to play an active role in family planning. Some of them are mentioned below.

1) 2.1.1 Services aimed at women and children

Before the sexual revolution initiated by the oral contraceptive, men were more of an integral part of family planning than they are today. If a couple wished to use contraception, their options were primarily limited to methods requiring male participation: withdrawal, periodic abstinence or condoms (Drennan, 2007).

Hormonal methods for women, beginning with the first oral contraceptive in 1960 (Cynthia et al 1999), and the subsequent development of intrauterine devices and modern tubal surgical sterilization, led to the development of family planning focusing on women (Cynthia et al 1999; Drennan, 2007).

Most family planning and reproductive health services are designed to meet women or children's needs and, as a result, men miss family planning information and services. It may be inconvenient or unwelcoming for men to visit a facility that primarily serves women and the providers may not have the training or skills necessary to meet men's reproductive health needs (FHI, 1998).

Traditionally, family planning programs have viewed women as their primary clients for two reasons: First, it is women who become pregnant and most contraceptive methods are designed for women. Research findings since the 1960s confirm that female are the major target of family planning programs and over 95 per cent of acceptors are females. In addition, the ratio of male to female sterilization acceptors has been strikingly unbalanced. The second explanation is that there are various temporary and easy-to-use contraceptive methods available for women and which are offered conveniently as part of maternal and child health services, while only condoms vasectomy and male traditional methods are available for men (Ndezako, 2008).

There have been many false believes by providers and policy makers about men. It is easy to say that men always want more children, are not interested in using contraception, do not care about spreading of STDs and HIV, do not share any responsibility of raising children, and perpetuates violence against women. Some programs have been designed on these assumptions and therefore exclude men from getting help to understand their needs and to change their harmful behavior. Surveys show that as men learn about contraception they want to use it, and as the pressure of raising large families increases, they want fewer children. In nearly all countries or cultures, there are men who share their parenting responsibilities and who stand-up against violence against women(Ndezako, 2008)(Chair & Arundhat., 2011).

Men and women are biologically partners in reproduction process and emphasis was put on women due to child bearing and rearing, but this naturally requires men. Most observers agree that family planning programs have made little effort to consider men's reproductive health needs or to reach men and that as a result men have few contacts with the reproductive health care system.

Some family planning programs have avoided serving men in the belief that woman need privacy and autonomy in reproductive health matters ((Hassan, Kaz, & Jahid, 2003)). In addition to that most of surveys, like the Demographic and Health Surveys, World Fertility Surveys and Contraceptive Prevalence Surveys are directed to women. Male interviews are rarely included in the Demographic and Health Surveys and usually men provide household characteristics like names, ages and the permission to interview women. Hence, conclusions were made on fertility attitude questions, even to their spouse based on women (Turgay, 2005).

The application of questions to men has started to change in most Demographic and Health Surveys, but the general tendency is to omit male questions, perhaps due to budgetary and organizational problems in the field. When there is shortage of money male questions are the ones to be discarded first because it is easier to reach women and

interview them in developing countries as they are usually house wives or working on family farms or doing business close to home. On the other hand, men are more mobile, harder to catch at home, the work-place more likely to be far, and it is more difficult to find them even on weekends or in the evenings (Ndezako, 2008).

2) 2.1.2 *Limited number of male contraceptive methods available*

The currently available male methods are limited to condoms, vasectomy, withdrawal, and abstinence. Like contraception for women, each of these methods has advantages and Disadvantages and a particular client will have to decide himself whether the particular method will meet his needs (Ndezako, 2008).

3) 2.1.3 *Rumors and misinformation*

Because of general lack of access to accurate information about male contraceptive methods, men may not know how to use them correctly or may have misperceptions and fears that prevent them from using the methods. For example, men may be unwilling to use vasectomy because they associate it with castration or believe that it leads to impotence. Similarly, they may be unwilling to use condoms because they believe condoms will reduce sexual satisfaction or cause allergic reactions(Ndezako, 2008)(Onyango, Owoko, & Oguttu., 2010).

4) 2.1.4 *Provider bias against male methods*

Providers may have misconception or biases about male methods or men's in family planning as a result; they may not present information about male methods or assume that men are not interested (Chair & Arundhat., 2011).

5) 2.1.5 *Unfavorable social climate*

In societies where sexual matters are not discussed openly, men may feel uncomfortable talking about their family planning needs and sexual concerns with their partners and with health educators. Young men may face particularly strong social pressures that prevent them from seeking reproductive health information and services. Interestingly, results of recent Demographic and Health Surveys among men indicate that in most countries men's approval of family planning matches the approval of women. And, of course, men have their own sexual and reproductive problems, which have not been adequately addressed(Francis J, 2008). For example, The Ankole fertility survey (Uganda) in 1999 showed that men have a positive attitude towards family planning methods, particularly modern methods despite their extreme low level of contraceptive use. While only 7% of men had practiced modern contraception including female methods, 65% said they were willing to use and allow their wives to use modern methods (Onyango, Owoko, & Oguttu., 2010).

B. 2.2 *Factors encouraging male participation in family planning.*

Several few factors have been found to encourage men participation in family planning including availability of free family planning services in all government hospital, reduced waiting time before being served at all hospitals and increased media advertisement.

C. 2.3 *Male methods of family planning.*

Male family planning methods are condom, vasectomy, withdrawal and periodic abstinence.

1) 2.3.1 *Condom*

The condom has been used for contraception for at least 250 years and as protection against sexually transmitted diseases ever longer than that ((Ndezako, 2008), <http://www.fp/conom/conom3.html>). Today high quality condoms are available in range of sizes, thickness, shapes, textures, and colors to appeal to different customers. This may result in many more men choosing to use condoms who previously abandoned the method(Kenya G. o., National Family Planning Guidelines For service providers, 2010).

a) 2.3.1.1 *Condom use worldwide*

About 46 million couples use condoms for family planning. Of these, 60% are in developed world mainly in Japan, USA and UK while 40% are in developing countries mainly in Asia (Abraha, Adamu, & Deresse, 2010)(Ndezako, 2008). Condom use is widely spread in Eastern Europe and the former Soviet Union. In Latin America and the Caribbean, condom use is highest in Jamaica, at 17% of married couples, and in Costa Rica, at 16%.

In Asia and the Pacific, condom use is highest in South Korea, where one in every ten married couple relies on condom. As with most other methods, condom use is low throughout most of Sub-Saharan Africa and the Near East and North Africa. Exceptions are Mauritius, where about 13% rely on condoms; and Zambia, about 4%. Elsewhere in these regions, about 2% or less of couples in surveyed countries report using condoms (John Hopkins School of Public Health, Population report, 1998,).

b) 2.3.1.2 *Advantages of condoms*

A condom is an effective way of family planning and STD/HIV prevent. It can be used to treat premature ejaculation, cheap and does not need medical personnel supervision, reduce risk of cervical cancer, almost every man is eligible to use the condom, there is no health risk associated with this method and they do not interfere with the act of intercourse as do the foaming tablets.(Hassan, Kaz, & Jahid, 2003)(Ndezako, 2008)(Kenya G. o., National Family Planning Guidelines For service providers, 2010).

c) 2.3.1.3 *Disadvantages of condoms*

Condoms have several disadvantages including; a new condom must be worn for each act of sexual intercourse, condoms have a high failure rate if used inconsistently or incorrectly, they might reduce sensitivity, condoms might cause itch to those people who are allergic to latex, they cannot be used with oil based lubricants, and finally condoms are affected by heat, light, and humidity.

2) 2.3.2. *Vasectomy*

This is the permanent method of birth control for men and is a popular method of family planning only in few countries. It is surgical operation that intends to cause sterility for men. Vasectomy blocks the vas deferens and keeps sperm out of the seminal fluid and the body instead of being ejaculated absorbs sperms. It does not affect masculinity, sexual organs, sexuality and sexual pleasure. There is no organ or glands removed or altered, hormones and sperms continue to be produced as before and the ejaculate will look like it always did and there will be about as much as before.

Vasectomy is not effective immediately because sperms remain in the system beyond the blocked tubes. Hence other birth control must be used and it usually takes from 15-20 ejaculations before the semen analysis shows no sperm in the seminal fluid or after 6 to 8 weeks ((Ndezako, 2008)(Kenya G. o., National Family Planning Guidelines For service providers, 2010)).

a) 2.3.2.1 *Vasectomy reversal*

Vasectomy can be reversed and the most single determining factor of reversal success is the duration after which the vasectomy was done. Within 3 years after vasectomy, reversal results in sperm recovery in over 97% of cases, from 4 to 8 years, about 91%; from 9 to 14 years, about 87%; and beyond 14 years, about 70%. However, it is expensive to have reversal done and is only available in few specialized centers and hence it should be considered as permanent method (Vasectomy study group, 2011).

3) 2.3.3 *Male traditional methods*

The male traditional contraceptive methods include periodic abstinence and coitus Interruptus (Withdrawal).

a) 2.3.3.1 *Coitus Inruptus (Withdrawal)*

Thirty-five million couples are estimated to use withdrawal worldwide (Onyango, Owoko, & Oguttu., 2010). The pregnancy failure rate is often higher because the man does not always withdrawal in time; still the method is available and cost nothing.

Among surveyed married women in developing countries, only 4% use withdrawal.

While in most regions withdrawal is not a common method, its use is substantial in some countries. In Turkey 26% of married couples rely on withdrawal for contraception; in Czech Republic, 22%; and in Mauritius, 16% (Francis J, 2008).

The method has been given little attention in most family planning programs because; it has low efficacy rate in pregnancy prevention and coitus dependent (Bloom, 2000).

Advantages and disadvantages of Withdrawal method:-

The main advantages of this method is that, it is available in any situation at any cost, it requires no supply, it does not need help from health care workers and lastly, it provide privacy for users. The main disadvantage of the method is high failure rate and this makes most of health personnel dismiss the method. Despite all these disadvantages, withdrawal is considerably better way to avoid pregnancy than not using contraception and some couples learn to use it fairly successfully (Chair & Arundhat., 2011).

b) 2.3.3.2 Periodic Abstinence.

It is estimated that about 17 million people worldwide use this method. To practice periodic abstinence, couples must be able to predict the woman's fertile period. The calendar/ rhythm involves calculations based on women previous menstrual cycles to estimate the time of ovulation. With the newer methods, couples are able to monitor physiological changes that occur with ovulation, like rise in basal body temperature, an increased slippery cervical mucus and change in the position and texture of the cervix. Other signs include inter-menstrual bleeding, mid cycle abdominal pains and breast tenderness. Some couples use barrier methods around the time of ovulation rather than to abstain, a practice sometimes called fertile awareness. In Japan, many couples use condoms in this way.

The use of periodic abstinence is substantial in some countries. For example, Bolivia, 22% of married couples use periodic abstinence; in Peru, 18%; and in Ecuador, 9%. In Vietnam, about 10% of the couples rely on the method, and in Philippines and Malaysia, 7%. In 10 countries of Sub-Saharan Africa, survey findings show that, at least 5% of couples use periodic abstinence as a family planning method.

D. 2.4 Female methods of contraceptives

1) 2.4.1 Hormonal contraceptives

They are among the most widely used FP method worldwide. In Kenya nearly 75% of all women use this method of contraception, with 32% and 61% choosing the pills and injectable contraceptives respectively(Kenya G. o., National Family Planning Guidelines For service providers, 2010). Hormonal contraceptives contain synthetic hormones (i.e. combination of estrogen and progestin, or progestin alone) which work primarily by preventing ovulation and making cervical mucus too thick for sperms to penetrate(Onyango, Owoko, & Oguttu., 2010). Some of the hormonal methods used in Kenya include; combined oral contraceptives, progestin- only contraceptive, progestin –only injectable contraceptive, progestin only contraceptive implants, hormone releasing intra uterine systems and emergency contraceptives.

2) 2.4.2 Intrauterine contraceptive devices (IUCD)

The IUCD is a flexible device that can be inserted into the uterine cavity by a trained service provider. There are two broad categories of intrauterine contraceptive devices i.e. the copper-based and the hormone releasing devices. Copper based devices release copper and work mainly by preventing fertilization; they reduce the number of viable sperms that reach the fallopian tube(Kenya G. o., National Family Planning Guidelines For service providers, 2010).

3) 2.4.3. Tubal ligation

This is a minor surgical operation that involves cutting and tying the fallopian tubes in order to prevent the sperm from fertilizing the ovum that was released from the ovary, and reaching the uterine cavity. In Kenya nearly 14% of users of modern contraceptives rely on female sterilization(Kenya G. o., National Family Planning Guidelines For service providers, 2010)(Kenya G. o., Kenya Demographic Health Survey, 2008-2009). Like vasectomy, tubal ligation is not reversible.

4) 2.4.4. Barrier methods

They prevent sperm from gaining access to the upper reproductive tract and making contact with the ova. These methods include female condoms, spermicides, diaphragms and cervical cups. Whereas condoms, diaphragms and

cervical cups are mechanical barriers, spermicides are chemical that interfere with the movement of the sperm and its ability to fertilize the egg.

5) 2.4.5. *Traditional/natural female methods.*

a) 2.4.5.1 *Locational amenorrhea (LAM)*

It's a temporary method of FP based on the lack of ovulation that results from exclusive breast feeding. LAM works primarily by preventing ovulation- but for this to occur, exclusive breastfeeding is mandatory. If effectively used, the pregnancy rate is about two per one hundred women in the first 6 months.

b) 2.4.5.2 *Fertility awareness based methods (FAMs)*

FAMs require abstention from intercourse during the fertile times of a woman's menstruation cycle, thereby avoiding conception. To achieve this, the woman must be able to recognize her fertile time

E. 2.5. *Men's knowledge and attitude about contraceptive use.*

1) 2.5.1 *Men's knowledge about contraceptive use*

According to a study conducted Ndenzako in Tanzania in 2008, almost 90 per cent of all men know at least one method of family planning. Among women the pills are the best known method (78%), while among men, condoms are the best known method (86%). The difference in knowledge between men and women is especially notable for male sterilization and condom: 35% of men compared with 25% of women know of male sterilization and 86% of men compared with 72% of women know about condoms.

Another study conducted in Nigeria found out that nearly all men (96.5%) were aware of FP and a majority of them were aware of some common FP methods, e.g. Oral pills (72.5%), injectable (69.2%), condom (86.6%) and Tradition method (70.6%). Knowledge of other alternative female methods was low, e.g. Norplant (17.5%), IUCD (26.3%) and diaphragm (39%).(Odu, Ijadunola, Komolofe, & Adebimpe., 2006).

In another study done in Wolaita Soddo town South Sudan, it was found out that about 96% of the men know at least one method. The most commonly reported family planning methods are pills (96%), injectable (Depo-Provera) 94.5%, condom 88.6%, Norplant 35.3%, intrauterine device 22.5%, Vasectomy 33.1%, Tubal ligation 33.1%, rhythm method 20.7%, Spermicidal 2.71% and other includes withdrawal method.

A study done in Kenya by Fapohunda and Rutenberg (1998) found that family planning awareness was high, but condoms and vasectomy were found to be stigmatized, and family planning was considered women's responsibility. Men gave Family Planning only limited support because they believed that contraceptive usage had an adverse effect on women's sexuality.

2) 2.5.2 *Attitudes of men towards contraceptive use*

In a study carried out in South Sudan 387(91.5%) of the respondent had desire to know more about family planning method, 25(5.9%) of the respondent had no desire to know family planning method, the rest 11 (2.9%) gave no response for this question. Men were asked whether they approve or disapprove (both the male and female method) the use of family planning method about 328 (77.5%) of the men approve the use of family planning at the time of the interview, while 80 (18.9%) disapprove the rest 3.5% gave no response for this question. The reason mentioned for disapproval 23(28.8%) were desire to have more children, 21(26.3%) respondent refusal, 9(11.3%) wife or partner refusal, 9(11.3) fear of side effect, 7(8.8%) religious prohibition, 11(13.5%) were others about 59.5% of married men discussed family planning in the last 1 year of those who discussed family planning 187 (73.9%) had frequent discussion while 17(6.7%) and 49 (19.4%) had discussed the issue of family planning once and twice respectively.

3) 2.5.3. *Men practice of family planning*

Despite the vast knowledge that men have about family planning, very few men actually use the family planning methods(Bloom, 2000). In a study carried out in South Sudan by Ndezeko 2008, among the 75.2% of those who had some knowledge in family planning, only 10% had once used a family planning method, most of whom had used a condom. The use of this other methods of FP is very low(Ndezako, 2008).

F. 2.6 *PROBLEM STATEMENT*

While many men know about contraception and approve of it in general, not all that approve of contraceptives use it. Some are not currently using contraceptives because they want another child. While others want to prevent

pregnancy but do not want to use contraceptives for a number of reasons that family planning programs should address. Large-scale survey as well as small studies done in Kenya as well as other countries indicate that men's family planning and other reproductive health knowledge, attitude and practices are more clearly understood now than before. Nevertheless, the picture is still incomplete and offers only a broad look at a group that is far more complex than survey statistics alone can suggest. The purpose of this study therefore is to endeavor to determine the factors that affect men involvement in FP. (Kabwingu Samuel 2001).

One of the main reasons for undertaking this study is that there has been little effort to promote the understanding of family and family planning so that appropriate policies, interventions and strategies could be made or undertaken in order to improve the quality of life of citizens and communities in Kenya and elsewhere in the world. It is hoped that the results of this study will assist the National Family Planning Program (NFPP) in designing programs that will help in raising the level of contraceptive use and, therefore, reduce the fertility in Kenya. Secondly, the results will also add more information towards a better understanding of factors that affect fertility in sub Saharan(Ndezako, 2008)

G. 2.7. JUSTIFICATION OF THE STUDY

Men's participation in family planning is a promising strategy for addressing some of the world's most pressing reproductive health problems. Men can prevent unwanted pregnancies and reduce unmet needs for family planning. Increased men's participation involves more than program activities conventionally associated with men. It also involves encouraging a range of positive reproductive health and social behavior by men to help ensure women's use of contraceptives.

Men's participation is crucial to enabling millions of women to avoid unintended pregnancies. Of the 175 million pregnancies each year, about 75 million are unintended according to estimates by the United Nations Population(Samuel, 2001).

Given the central role that males play in decision making and low levels in contraceptive use, a study to identify the factors affecting male participation is to open up avenues to promote contraceptive use in the study area and the entire Nation at large.

H. 2.8. RESEARCH QUESTION

What are the factors affecting male involvement in family planning in Sichilayi sub-location?

I. 2.9. RESEARCH HYPOTHESIS

There is a relationship between knowledge level of family planning and uptake by men in Sichirai sub-location

J. 2.10. BROAD OBJECTIVES

The main aim of this study is to determine the factors affecting male involvement in family planning in Sichilayi sub location.

K. 2.11. SPECIFIC OBJECTIVES

1. To determine the level of knowledge on contraceptive methods among men in Sichirai sub-location.
2. To determine the different types contraceptive use among men in Sichilayi sub location
3. Determine factors which motivate men to participate in family planning.
4. Determine factors prohibiting male participation in family planning.

L. 2.12. OPERATIONAL DEFINITION

M.

Knowledge - is awareness of the presence of the methods, type of FP methods, their sources, and their uses. The study subjects' knowledge of FP classified as good, fair and poor according to the number of correct responses to the series of six knowledge questions.

Attitude: Evaluation judgments good-bad about particular objects, issues, persons or any other identifiable aspect of the environment. Attitudes are divided into three classes: cognitive (thought, believes), affective (emotions) and behavioral (overt actions).

Practice– is the use of FP on the basis of their knowledge when the study subjects are exposed to unprotected sexual intercourse to prevent an intended pregnancy.

Male involvement: The way men accept and indicate support for their partner's needs choices and rights in contraceptive use and the men's use of contraceptives.

Chapter three

Research methodology:-

This chapter discusses the research design, study settings/area, study population, the sample and sampling procedures, data collection instruments, validity and reliability of the research instruments, pilot study, data collection procedures and data analysis, interpretation and presentation.

N. 3.1 Study design

This study will adopt the cross sectional study design

O. 3.2 Sampling technique

Since most of the men in Sichirai sub-location in work in town during the day, Snowball non probability research design will be used in this study. Few men from this sub-location will be interviewed in town, and then they will be asked to provide information needed to locate other men in town who come from Sichirai sub-location

P. 3.2 Study area

1) 3.2.1 Location

It's located in Kakamega county, Lurambi constituency, Shieywe location. It is about two kilometers from Kakamega town off Kakamega-Webuye. The sub location has an area of about 15.3km².

2) 3.2.2 Population

The population of sichirai sub-location is 38, 249 people, of which 19,293 are women and 18,956, are men. The area has a total of 27 villages with 10,475 households.

3) 3.2.3 Climate

The sub location receives adequate rainfall of 32ml annually. The rainy season starts February and end in August, then the rest of the period is dry.

Figure 1:- Map showing Sichirai sub-location.

4) 3.2.4 Economic activity

The main activities in the district are agriculture and small-scale business. The majority of the households earn their living from small-scale subsistence farming.

Agricultural production is basically for consumption and the district domestic market.

Sugarcane is the only established cash crop, but some few farmers also plant tea.

5) 3.2.5 Education

There are 5 public primary and 1 secondary school, Masinde Muliro University of Science and Technology, several other university campuses and middle level colleges such as University of Nairobi (UoN), Jomo Kenyatta University of Agriculture and Technology (JKUAT), Kenyatta University (KU), Mount Kenya University (MKU) and Kenya Institute of management (KIM) among others.

Q. 3.3. Sample size

The sample size was obtained using the Fishers formula

$$n = \frac{z^2 pq}{d^2} \quad \text{therefore; } n = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2} = 384$$

Sample size = 10%*n* + *n*₀

Sample size, *s* = $\frac{(10 \times 384) + 384}{100} = 422$ men

Where *z* is the *z* value taken to be 1.96

P is the percentage picking choice taken to be 0.5

d is the confidence interval taken to be 0.05

R. 3.4 Instruments development and implementation

The study will adopt the use of interview schedule, questionnaires and focused group discussions.

S. 3.5 Training & data collection process

The data collectors will be trained prior to pilot study and the real study to avoid differences in interpretation of some questions and ensure correct collection of data.

T. 3.6 Pilot study/ pre-test

A pilot study will be carried out in Lurambi village in order to test the validity and reliability of the data collection instruments.

U. 3.7 Validity and reliability of the data

V.

The representativeness of the data may be distorted from the selection of study participants, confounding, follow-up, measurements, analysis, and interpretation biases (Ndezako, 2008). In this study, selection bias and confounding will be taken care of by randomization. In addition, training of the research assistant who will be closely supervised by the principal investigator will be done to reduce biases.

In qualitative research, validity problems may appear during description, interpretation or theory (Maxwell, 1996). By comparing and relating data from different sources, it is possible to establish the credibility of the findings (Maxwell, 1996). To understand the knowledge, attitude and use of family planning methods among participants, data from FGD (Focused Group Discussion) and interviews will be compared in order to judge the important plausibility of the answers.

W. 3.8 Data Analysis

1) 3.8.1 Quantitative data

The data will be analyzed using SPSS. Descriptive statistics procedures will be employed during the data analysis. Descriptive statistics will be used to compute chi-square for contingency tables, and inferences for chi-square tests will be based on *p*-values. The statistical significance will be considered when the *P*-value will be below or equal to 0.05. All tests will be two sided. Cofounders will be corrected using multivariate analysis (binary logistic regression) and where numbers will be small Fisher's exact method will be employed.

The statistical inference for logistic regression will be determined by calculating 95% confidence intervals (CI) for the prevalence odds ratios (OR).

2) 3.8.2 Qualitative data.

Analysis of focus group discussions will include re-ordering of discussion topics, ordering of emerging issues in the discussions, transcriptions and making summaries. Sorting and ordering of responses from semi-structured interviews will done and grouped into themes. The recurring statements and narratives will be summaries.

X. 3.9 Expected results

Low level of male participation in FP is and in all dimensions of knowledge, attitude and practice is expected.

Y. 3.10 Ethical Considerations

This proposal will be approved by the Higher Degrees Ethics and Research Committee of Masinde Muliro University of Science and Technology. All the respondents will be provided with a consent form before filling the

questionnaire. For ethical reasons, the participants will be free to refuse to be interviewed. All the respondents will be free to ask any question about the research at any given time.

Z. 3.11 Research limitation

The research will be carried out in a rural setting, and the respondents may create information bias with socially acceptable answers. Assuring confidentiality by telling interviewees that their response will be treated confidentially and their name would not be required during interviews would reduce the bias.

Chapter four

Results:-

Socio-demographic data

In total, 420 males participated in this study. The mean age of the respondents was 37.6 years. Protestant Christians (63%) were the major religious group, followed Catholics (34%) then Muslims (3%). About 80% of the respondents were married and 20% were single and about 90% were in a monogamous type of marriage and 10% were in a polygamous marriage. 3% of the respondent had non-formal education, 54% had primary education, 29% secondary education and 14% had tertiary education level. On the other hand, 3% of the respondents' spouse had non-formal education, 54% had primary education level, 33% secondary, and 10% had tertiary education level.

Business men comprised the majority of the respondents (59%), followed by Jua kali men (14%), farmers 13%, teachers 11% and finally students 3%. On the other hand, most of the respondent's spouses were farmers (204, 53%), business women were 22%, House wives comprised 19%, and teachers were 6%.

Most of the respondent had 1-2 children (46%), followed by 3-4 children (27%) then 5-6 children were (13%). 7% of the respondents had 7-8 children and a similar percentage had no children.

Table 1:- Socio demographic characteristics of men in Sichirayi Sub-Location (n= 420)

Variables	Respondents		
	frequency	Percentage	
Age	18-35 yrs.	20	57
	36-59 yrs.	14	40
	>60 yrs.	1	3
Religion	Protestants	22	63
	Catholics	12	34
	Muslims	1	3
	Others	0	0.0
Education of Respondent	Non Formal Education	1	3
	Primary	19	54
	Secondary	10	29
	Tertiary	5	14
Education of the Spouse	Non Formal	2	3
	Primary	20	54
	Secondary	10	33
	Tertiary	3	10
Occupation of Respondent	Farmer	5	13
	Teacher	4	11
	Business	22	59
	Civil Servant	0	0.0
	Student	1	3
	Others(Jua Kali)	5	14
Occupation of Respondent	Farmer	19	53
	Teacher	2	6
	Business	7	22
	Civil Servant	0	0.0
	Student	0.0	0.0

	Others(House Wife)	6	19
Number of children	1-2	168	46
	3-4	96	27
	5-6	48	13
	7-8	24	7
	No child	24	7

Knowledge about FP

Participants' knowledge of contraceptives was examined in this survey. All 420 respondents had heard of family planning. Respondents were also asked the meaning of family planning, 77% said that FP is having the number of children one can cater for, 8% said that it is to avoid unwanted pregnancy, 6% said FP is preventing people from delivering children with a similar percentage saying it is regulating interval between pregnancies. 3% do not know what FP is. Participants were also asked if they knew any method that could be used to prevent or delay pregnancy, 94% of the respondent knew at least one method, with the remaining 6% did not know of any FP method that could delay or prevent pregnancy. Of those who knew at least a method that could prevent or delay pregnancy, majority mentioned the condom. Below is a table showing men's knowledge about FP in Sichirayi sub- location.

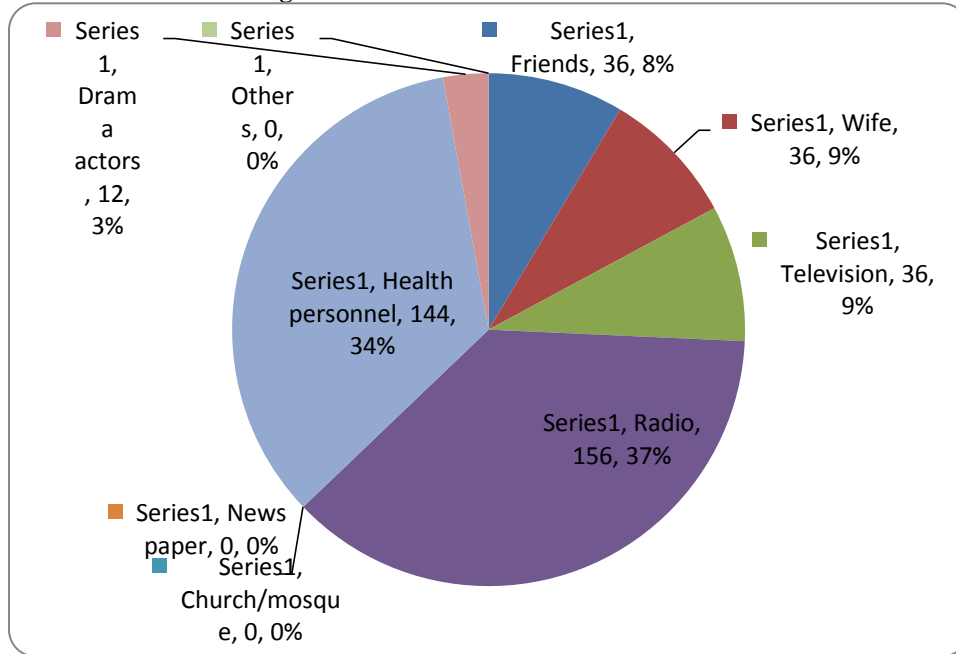
Table 2:- Men's knowledge about FP

Variables	Respondents		
	NO	%	
Heard of FP	Yes	420	100
	No	0	0.0
If yes, meaning	Prevent people from delivering children	24	6
	Avoid unwanted pregnancy	36	8
	Having the No. of children one can cater for	324	77
	Regulating interval between pregnancies.	24	6
	Do not know	12	3
Ever heard of FP method	Yes	396	94
	No	24	6
Source of information about FP	Friend	36	9
	Wife	36	9
	Television	36	9
	Radio	156	36
	Church/mosque	0	0.0
	News paper	0	0.0
	Health personnel	144	34
	Drama actors	12	3
	Others	0	0.0
FP method that can be used by a man	Pill	0	0.0
	Injection	60	14
	IUCD	0	0.0
	Norplant	24	6
	Abstinence	0	0.0
	Condom	288	68
	Foam	0	0.0
	Gel	0	0.0
	Male sterilization	24	6
	Counting days	12	3
	Withdrawal	12	3
Advantages of FP	Health reasons(prevent diseases)	48	12
	To have enough children	48	11
	Economic/financial reasons	156	37

	Spacing children	168	40
	Others	0	0

Most of the respondents (37%) had got the information about FP through the radio, followed by health personnel (34%). 9% of the respondent had heard about it on television, with a similar percent having got the information from their wives and friends. A small percentage (3%) had heard it from the drama actors. Below is a pie chart showing men’s sources of information about FP in Sichirayi sub- location

Figure 2:- sources of information about FP.



When asked about the method that can be used by a man to prevent his partner from getting pregnant, 68% of the respondents chose the condom, those who chose on injection were 14%, and both Norplant and male sterilization had 6%. Those who choose on withdrawal were 3% with a similar percentage choosing on counting days. 40% said that the FP has the advantage of spacing children, 37% said they would do FP for economic/ and financial reasons, those who said they do it for health reason were 11% , with a similar percentage saying they do it to have enough children. Most of the respondents reported that after their wives use the FP methods they always have reduced libido, as one of them reported;

“After using those pills, my wife’s sex appetite reduces”

Attitude about FP:-

When asked about their opinion on family planning, many men said that FP is a good idea and they agreed to be involved in FP since this will help. Most of those who responded said that they only do not agree with doing vasectomy since it may deny them their manhood, as one of them said;

“Family planning is good, the only bad thing with it is vasectomy, what would happen if you do vasectomy then you realize that the children you are taking care of with your wife are not yours, it will be had to get your own children. To add on that, when you want to have more children, with vasectomy you won’t be able; you will also be disrespected in the community”

Most of the men consider vasectomy as a form of sterility, and the community does not respect sterile men. More so, they argued that they will only be fully convinced to be part of the FP campaign if there is reduction in the number of side effects associated with FP.

On the question about the role of men in family planning, most of the respondents said that men should only encourage their wives to get FP methods from the hospital. A small number said they can also use family planning methods along -side their partners while others argued the men have no role to play in family planning.

About male involvement in FP, 91% of the respondents said that men should be involved in fp, while the remaining 9% said that men have no role to play in FP. The men were also asked about possible factors that hinder men from being involved in FP, 324(77%) of the respondents said that lack of information about family planning is the cause, 17% said that men have no time for family planning and 6% had other reasons like fear of side effects and n access t FP services. When asked whether the FP services for men should be offered in the same clinics as women, only 43% agreed with idea of using the same clinic with women but remaining 57% argued the men should have their own clinics separate from those of women. Those who want men to have their own clinic say that men are ashamed of sharing the same facility with women, as one of them reported;

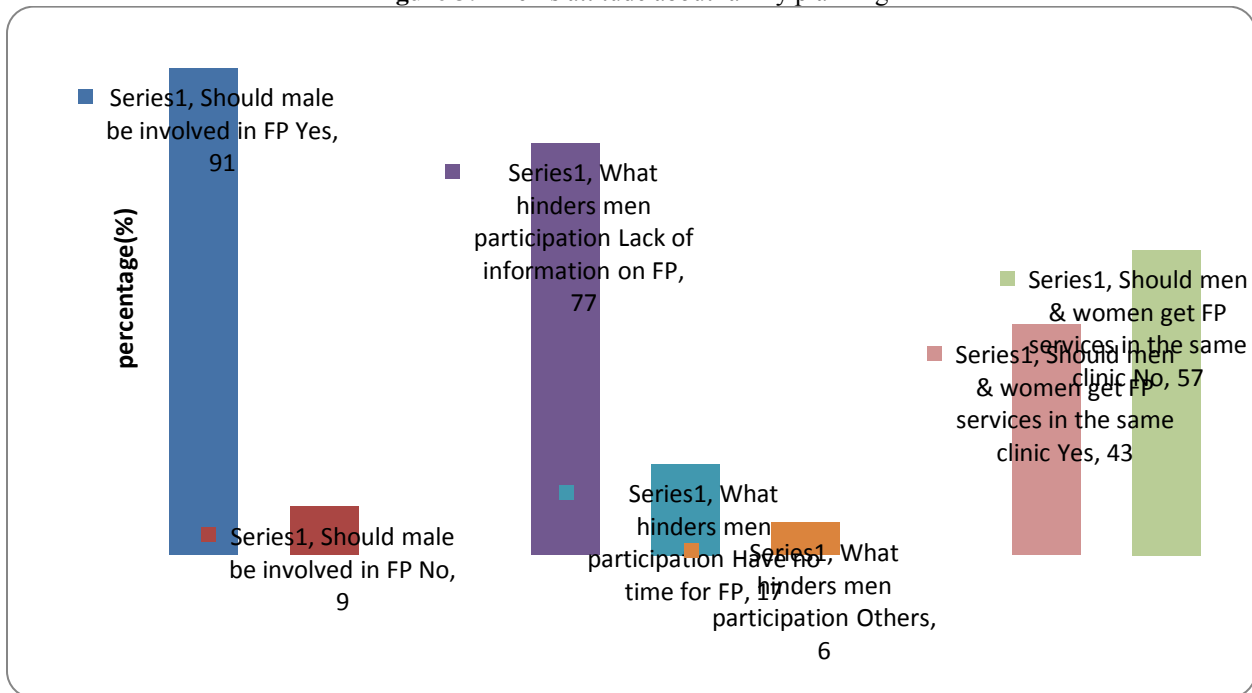
“We men should be given our own clinics, we cannot line up with women in the same clinic as we wait for service, and our culture does not allow us. Also to reduce congestions in this clinic it is essential that we be given our own clinics”

When asked about why many men stop their spouse from using family planning, majority of the respondents cited the side effects as the main reason, as one of them responded;

“I cannot allow my wife to use these FP methods since every time she uses them she loses sexual appetite, increases body weight, and has prolonged menses I also heard that using these methods of FP may cause congenital abnormalities on the children you bear”

Majority of the respondent said that to encourage more men to FP, this services should be made available near their places of work, vasectomy should be stopped and the FP method should be re-evaluated to make sure there are no side effects.

Figure 3:- Men’s attitude about family planning

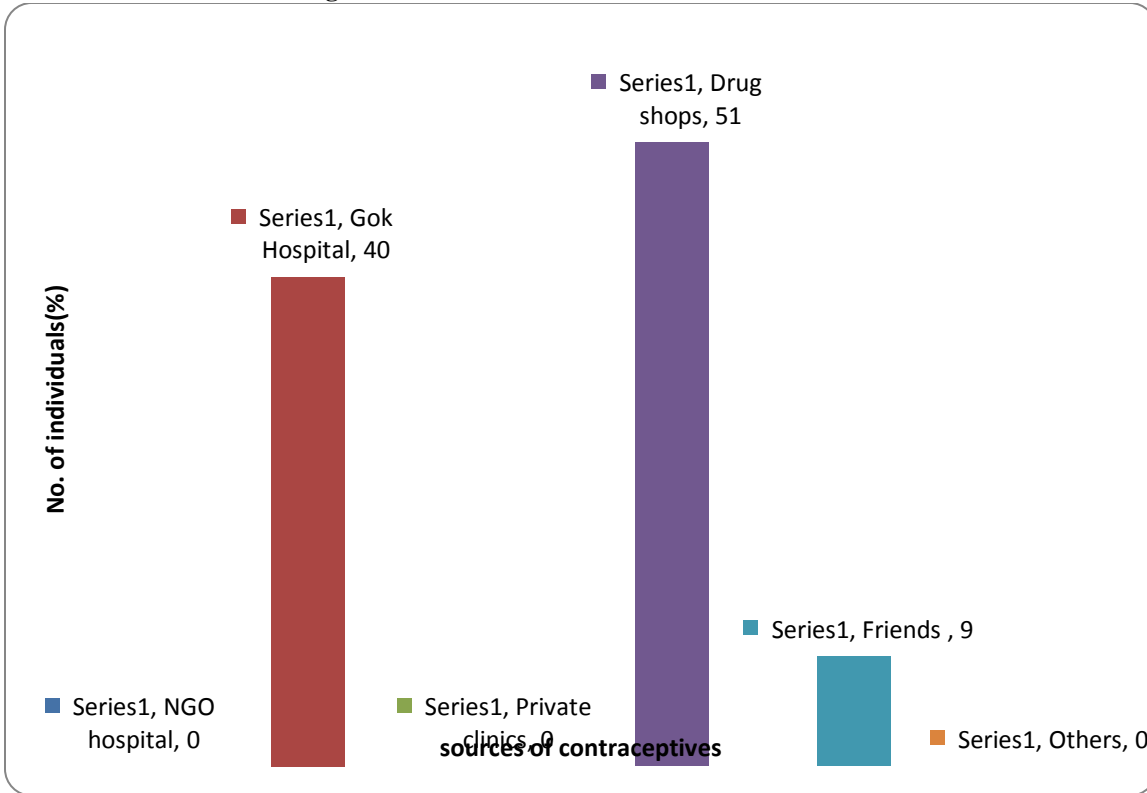


Practice of FP.

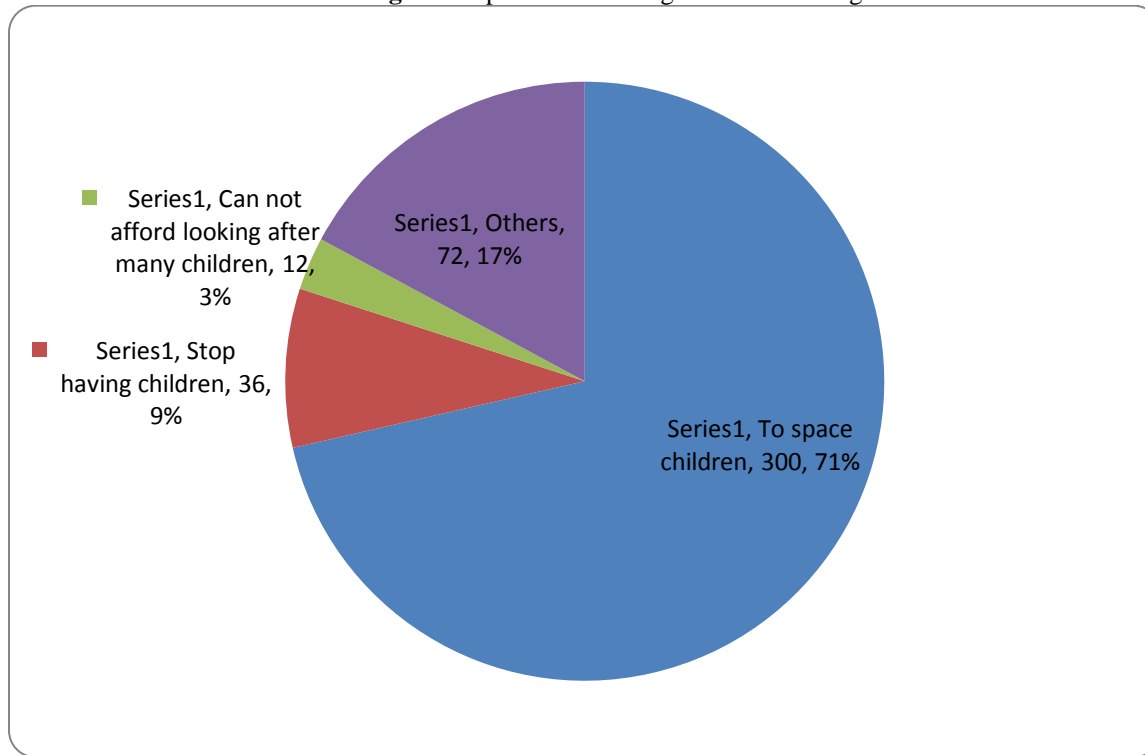
The respondents were also asked whether their spouses use any FP method, 77% said that their spouses use while the remaining 23% said their spouses do not use any. Many of those who use FP reported they use the three month injection while a small percentage use the Norplant and the pills. Those whose spouses do not use blamed the side effects as the main reason. When asked if they have ever used any FP method to prevent a woman from getting pregnant, 91% of the respondents reported that they have ever used these methods, and all of them mentioning the condom as the method. The remaining 9% said they have never used any FP method. Among those who had not

used any method, 67% reported the need for more children as the reason why they are not using FP, while the remaining 33% said they do not know the FP methods. On the question about the source of the FP methods, 51% of the respondents get the FP methods from the drug shop, 40% get them from government hospitals and 9% get them from friends.

Figure 4:- The distribution of sources of FP for men



The participants were also asked why they decided to use FP and 71% of the respondents cited spacing children as the main reason, 17% said they do it for health reasons, 9% do it to stop having children and 3% said they cannot afford looking after children.

Figure 5:- pie chart showing reasons for using FP

They were also asked if they intend to use FP in future and 94% of the respondents had the intension while another 6% had no intension. All those who did not have the intension gave the reason of not knowing the methods. When asked if they have ever discussed with their partner the number of children they would like to have, 89% reported having discussed while the remaining 11% had not discussed. Most of those who had discussed had agreed on having 4-5 children. 89% of the respondents reported having discussed with their spouses the on the type of FP method to use, of which 47% had agreed to use the three month injection, 20% condom, 18% Norplant and 15% had decided to use pills.

Chapter five

Discussion:-

The study assesses the involvement of men in family planning method utilization in Sichirai sub-location. Involving men and obtaining their support and commitment to family planning is of crucial for family planning service utilization. This paper focuses the importance of involving men in influencing the utilization of family planning method and highlighted the potential insights into men's behavior where family planning interventions could be made. Most of the respondents (240) belong to the age bracket of the youth (18-35) this could be due to the affordability of the motorbike and increased unemployment of the youth. A bigger percentage (80%) of the respondents were married, this is attributed to the presence of an income generating activity that the men had.

Most of the men who were interviewed (54%) had only attained primary education with a similar percentage of their spouse having acquired the same level of education. This shows that the level of education of the man will determine education level of the spouse, which subsequently will determine the decision to use or not use contraceptive(Chair & Arundhat., 2011). 59% of the respondents comprised of business men, this could explain why most of the men said they do not have time for family planning. Most of the respondent's spouses (53%) were peasant farmers; this explains why family planning matters have been left for the women

There are variations in the types of family planning method practiced in the study area. Male method such as vasectomy and condom were utilized poorly. Source of contraceptive and not known fear of side effects, were among the reasons reported for low utilization of family planning.

Men knowledge on family planning is very high compared to another study done in Tanzania by Ndenzako (2008) where the knowledge was 88%, in this study 96% of married men know at least one method of family planning. This might be the result of intervention by the health sector and increase exposure to media (radio)(Abraha, Adamu, & Deresse, 2010).

In this study, Men's attitude about family planning was very good compared to another study done in Tanzania by Ndenzako (2008).a majority of the respondents agreed that men should be involved in FP since this will not only help them, but also the society at large. The only problem that most men do not like in FP is vasectomy, which most of them consider it as a way of taking away their manhood. This is contributed largely by their cultural beliefs and lack of adequate information about what vasectomy is all about(Onyango, Owoko, & Oguttu., 2010). A bigger percentage of men (57%) said that men should have their own clinic separate from those of women where they can collect their contraceptives. This is thought to be a result of the cultural belief that men should not share anything with men due to their superiority(Francis J, 2008).

Even though we have a number contraceptive sources around the area, majority of the men (51%) do obtain the FP methods from the drug shops, this is thought to be due to their quick access compared to this other sources, and also the privacy associated with their acquisition, since men would not want to be seen with contraceptives(Onyango, Owoko, & Oguttu., 2010)

Spacing children (71%) was found to be the main reason why most people use family planning in Sichirayi sub-location; most of them said they wanted to give their spouses rest time before the next pregnancy. Those who do not use FP gave a reason of unknown side effects. This could be as a result people misinformation from some members of the community of whom may not have ever used the FP methods(Chair & Arundhat., 2011).

It was encouraging to find out that many men (94%) were intending to use FP in future due to its advantages which outweigh the disadvantage. This could be attributed to the increased sensitization and knowledge about FP among men.(Abraha, Adamu, & Deresse, 2010)

Chapter six:-

Conclusion:-

The main aim of this study was to find out the factors that affect male involvement in FP, it is evident that the main reason that hinders men from involving in FP is unknown side effects, lack of time for family planning, cultural restriction and lack of availability of a wide range of family planning options.

The study found high prevalence of knowledge of contraceptive methods among married men, low utilization of male methods of family planning. Men's attitude about FP was also found to be high since most of the men were of the idea that they have a role in FP. This was the opposite of the result of another study done in Bangladesh in 2011 that found very poor attitude of men towards use of FP. Men's practice of family planning was found to be low but better than that of the previous study done in Kisumu by Anyango et.al(2010)

Recommendation:-

Family planning methods use among married men is above average but below what is expected. For this purpose, governments, nongovernmental organizations (NGOs), donors' agencies and relevant stakeholders should ensure availability, accessibility and sustained advocacy for use of condom for protection against unwanted pregnancy.

Health institution should improve the availability of men family planning method through resource mobilization from partners (NGOs) and different actors.

More education through the media should be implemented to increase the knowledge and attitude of married men in family planning method.

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APPENDIXES

AA. CONSENT FORM

My name is Etole Bravin, I am a student at Masinde Muliro University of Science and Technology, undertaking a Bachelor of Science in Nursing.

As a requirement of the course, I am undertaking a research on male involvement in FP at Sichirai sub-location. I am pleased to inform you that you have been identified as a potential respondent to the research. Be sincere and true to enable me get the required information.

Note that this is not an examination and there is no right or wrong answer. The information you give will be treated with a lot of confidentiality and shall be used for academic purpose only.

Consent given: Yes (sign).....

BB.

CC.

DD.

EE.

FF.

GG.

HH.

II. Appendixes

QUESTIONNAIRE ON MALE INVOLVEMENT IN FAMILY PLANNING. A CASE STUDY IN SICHILAYI SUB LOCATION

Serial No.....

SECTION A:

#	Socio-demographic characteristics	Responses	Coding
1	Age	_____ yrs.	
2	Religion	1=Protestant 2=Catholic 3=Muslim 4=Others (specify).....	
3	Marital status.	1. Married 2. Single 3. Divorced 4. Separated 5. Widowed 6. Cohabiting	
4	If married nature of marriage or stable union.	1. Monogamous 2. Polygamous	
5	What is your educational Level?	1. No formal education 2. Primary 3. Secondary 4. Tertiary	
6	What is the education level of your spouse	1. No formal education 2. Primary 3. Secondary 4. Tertiary	
7	What is your occupation?	1. Peasant 2. Teacher 3. Business 4. Civil servant 5. Student 6. Others (specify).....	
8	What is the occupation of your spouse?	1. Peasant 2. Teacher 3. Business man 4. Civil servant 5. Student 6. Others (specify).....	
9	How many children (living children) do you have?	1. 2 2. 3-4 3. 5-6 4. 7-8 5. 9-10 6. > 11 7. none	

SECTION B

ASSEMENT OF KNOWLEDGE

10	Have you ever heard about Family Planning?	1. Yes 2. No	
11	If yes, what is the meaning of family planning?	1. Preventing people from delivering children. 2. Avoiding unwanted births 3. Having the number of children that one can afford to cater for 4. Regulating intervals between pregnancies 5. Do not know	
12a	Have you heard of any method which can be used to prevent or delay pregnancy?	1. Yes 2. No	

12b	If yes specify	
12c	If yes, where did you get the information?	1. L.C 2. Friends 3. Wife 4. Television 5. Radio 6. Church/Mosque 7. News paper 8. Health personnel 9. Drama actors 10. Others (specify).....	
13	Which method do you know that can be used by a man to prevent his partner from getting pregnant?	1. Pill 2. injection 3. IUCD 4. Norplant 5. Abstinence 6. Condom 7. Female sterilization 8. Foam 8. Jelly 9. Male sterilization 10. Counting days (safe periods) 11. Withdrawals 12. Others.....	
14	What are the advantages of family planning?	1. Health reasons 2. To have enough children 3. Economic/financial reasons 4. Having a rest (spacing children) 5. Others(specify).....	
15	What are the disadvantages you have heard about family planning?	State.....	
Section C. Assessment of Attitude			
16	What is your opinion about family planning?	State.....	
	Men's Role		
17	What do you think is the role of men in family planning?	
18	Do you think men should be involved in family planning?	1. Yes 2. No	
19	Do you think men should be involved in family planning?	1. Yes 2. No	
20	What do you think prevents men from participating in family planning?	
21a	Do you think men should get family planning services from the same clinics as women?	1. Yes 2. No	
21b	If yes, give reasons?	Reason.....	
21c	If no why?	Reasons.....	
22	Give reasons why men stop their women from using Family Planning?	
23	What do you think	

	should be done to encourage men to participate in FP?		
SECTION D. ASSESMENT OF PRACTICE			
24a	Does your partner use family planning methods?	1. Yes 2. No	
24b	If yes, which method does she	
24c	If No. Why not using –	
25a	Have you ever used any method of family planning to prevent a woman from getting pregnant?	1. Yes 2. No	
25b	If yes	Specify.....	
25c	If no, why not?	1. Not married 2. Wants more children 3. Does not know about the method	
25d	If yes, which method did /do you use?	1. Withdrawal 2. Condom 3. Pills 4. Diaphragm 5. IUCD 6. Norplant 8. Female sterilization 9. Foam/Jelly 10. Safe period 11. Abstinence 12. Others (specify).....	
26	Where did (do) you go to obtain the method?	1. NGO hospitals 2. Government hospitals 3. Private clinics 4. Drug shops 5. from friend 6. Others (specify).....	
27a	Why did you decide to use family planning?	1. To space children 2. To stop having children 3. Cannot afford to look after many children 4. Others.....	
27b	If No, do you or your partner intend to use a method to avoid pregnancy?	1. Yes 2. No	
27c	If No, what is the main reason for not using a method?	1. Not married 2. Partner does not want 3. Religion does not allow 4. Does not know methods 5. Wants more children 6. Others (specify).....	
28a	Have you and your partner ever discussed the number of children you would like to have?	1. Yes 2. No	
28b	If yes, how many children would you	

	like?		
29a	Have you ever discussed with your partner the method of family planning you would use?	1. Yes 2. No	
29b	If yes, which method would you or your partner prefers to use?	1. Pill 2. Injection 3. Norplant 4. Condom 5. Diaphragm 6. Male sterilization 7. Female sterilization 8. Foam 9. Jelly 10. Abstinence 11. Folk method 12. Others (specify).....	
29c	If No, why?	