Gender based perceptions on use of Family Planning among Marakwet Community in Koibarak Location, Elgeyo Marakwet County, Kenya

BY

ANNE K. YANO

A Thesis Submitted to School of Public Health, College of Health Sciences, Department of Health Policy and Management in Partial Fulfilment of the Requirements for the Award of Degree of Masters of Public Health in Health Promotion

Moi University

2022

DECLARATION

Declaration by the Candidate

This thesis is my original work and has not been presented to any other university/institution. No part of this research thesis may be reproduced without the prior permission of the author or Moi University

Signature..... Date…….....

Anne K. Yano

SPH/PGH/35/13

Declaration by the Supervisors

This thesis has been submitted for examination with our approval as the University Supervisors.

Signature..... Date…….....

Dr. Serah Odini
Department of Health Policy and Management & Human Nutrition,
School of Public Health,
College of Health Sciences,
Moi University,
ELDORET-KENYA.

Signature..... Date…….....

Prof. Joice Baliddawa
Department of Mental Health and Behavioural Sciences,
School of Medicine,
College of Health Sciences,
Moi University,
ELDORET-KENYA.

DEDICATION

I dedicate this work to my family members for their continued support.

ACKNOWLEDGEMENTS

I wish to thank the Almighty God for giving me the life, strength, patience and wisdom to start and complete this work successfully. To God be the glory and honour.

I am deeply grateful to my supervisors Dr. Serah Odini and Prof. Joice Baliddawa for their professional guidance and close supervision that enabled me to complete this work. I say thank you very much and God bless you.

To my husband Samuel and my children Kipruto, Kipsang and Faith, you have been a source of hope and encouragement. You really demonstrated never ending understanding, unconditional love, constant encouragement and prayers during the entire study period.

Last but not least, I most sincerely thank my classmates for their moral support, my family members for their continued encouragement and support and Moi University, College of Health Science for offering me the opportunity to undertake my postgraduate studies.

ABSTRACT

Background: Globally recipient perceptions research is low. Especially in relevance to perception on the use of family planning methods. This is even lower in developing countries which are still operating on a patrilineal dominated values and cultures. It is within this framework that service delivery must be understood. Gender based perception is an area that needs investigations in order to guide appropriate intervention measures where gender is a factor for consideration in service provision and delivery. This study explored gender-based perception of respondents in Koibarak Elgeyo Marakwet

Objectives: The purpose of the study was to investigate the gender-based perceptions on use of family planning among Marakwet community in Koibarak Location, Elgeyo Marakwet County. The study was guided by the following objectives: to examine the perceptions of family planning methods by men and women; to identify the perspectives on the use of family planning; and to establish the perceived challenges faced in relation to usage of family planning methods between men and women from the gendered perspective.

Methods: In-depth interviews and FDG's were used to get information from respondents aged between 21-49 years. The respondent's participation was purposely selected. Qualitative methods were used to explore perception from a gender based perceptive. A guide with generations related to perceptions on FP with focus on attitude, knowledge and practice. The unchanging purpose tries to seek perception from gender dimension on issues related to decisions and gender-based dynamics.

Data collection process involved discussions and interviews being recorded, transcribed verbatim and analysed and subjected to content analysis with thematic focus on attitude, knowledge and practice. A gender-based analysis was undertaken to unravel underlying gender-based similarities, differences and perceived challenges with respect to family planning methods and practices.

Results: The study findings established that participants were aware of the various family planning methods that exist. A total of 87 respondents were interviewed, using in-depth interviews and focussed group discussion. Results showed that they use modern contraceptives which include the use of pills, injections, implants, condoms as well as coil. Spouse refusal, fear of perceived side effects, accessibility of family planning methods, cultural hindrance, religious hindrance and lack of knowledge on family planning were identified as the major challenges affecting adoption of family planning methods in Marakwet.

Conclusions: The study concludes that despite the enhanced awareness of most couples on modern family planning methods, many have not adopted these methods due to various factors. Similarly, some residents still prefer traditional birth control systems.

Recommendations: The County Government of Elgeyo Marakwet through its ministry of health should intensify gendered campaigns and sensitizations on the importance and benefits of adopting modern family planning methods. Similarly, all the stakeholders in health both at the county and national levels to encourage constructive partner communication and engagements through campaigns in order to promote gender equity and equality in the adoption of family planning decision making. Also, awareness creation through seminars, barazas and health forums in order to increase awareness and knowledge-ability on the use of modern family planning should be intensified.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATION AND ACRONYMS

C:	Centigrade
CPR:	Contraceptive Prevalence Rate
DHS:	Demographic and Health Survey
DR:	Doctor
FP:	Family Planning
FGD:	Focused Group Discussion
HBM:	The Health Belief Model
IUD:	Intrauterine Device
KM^2:	Square Kilometres
Kshs:	Kenyan Shillings
MDGs:	Millennium Development Goals
MM:	Millimetres
NACOSTI:	National Commission of Science, Technology and Innovation
NBS:	National Bureau of Statistics
NGO:	Non-Governmental Organizations
NIPSMI:	National Institute of Population Studies and Macro International
PDHS:	Pakistan Demographic Health Survey
PGH:	Post Graduate in Public Health
SPH:	School of Public Health
TDHS:	Tanzania Demographic and Health Survey
TFR:	Total Fertility Rate
UNFPA:	United Nations Population Fund
URT:	United Republic of Tanzania
USA:	United States of America
USAID:	United States Agency for International Development

DEFINITION OF TERMS

Assess: it was used to mean measure or determine how one variable influence the other

Challenges: It referred to the hurdles faced in the use of various family planning methods. Variables such as misunderstanding among couples, illiteracy, and lack of information among others were used to measure challenges.

Family Planning Methods: It referred to techniques, types and strategies that families use in controlling the number of children in a family and the intervals between their births

Family Planning: The practice of controlling the number of children in a family and the intervals between their births, particularly by means of artificial contraception or voluntary sterilization.

Gender Based Perception: a view on family planning methods from both men and women. For instance, both men and women were asked whether they like family planning methods adopted and why.

Gender: A socio-cultural role attachment of men and women

Perception: The state of being or process of becoming aware of something through the senses, reflected in by attitudes, knowledge and practice

Utilization: It referred to putting into use for instance various family planning methods. For instance, the study will determine the various family planning methods such as pills, contraceptives, condoms among others that residents have adopted and are using.

CHAPTER ONE

INTRODUCTION AND BACKGROUND INFORMATION

1.1 Introduction

This chapter entails background information, statement of the problem, purpose of the study, objectives of the study, research questions, and justification of the study, scope and limitation of the study as well as definition of terms. The role of family planning is important for both men and women. This not only to reduces fertility rates by providing contraceptives options, but also expands their perception on their reproductive health. The main activities of family planning programs are provision of contraceptives and education related to reproductive health, especially to women (Kim, 2016). General school education to women is also supposed to have an effect on fertility rates. Many studies show that educated women get married at a later age than non-educated women, and have better access to contraceptives than non-educated women (Mboane & Bhatta, 2015).

1.2 Background to the Study

1.2.1 Global Perspective on Perceptions on Use of Family Planning

Globally, an estimated 225 million women have unmet need for family planning. Increasing acceptance and use of family planning requires more than increasing access to health services: truly effective family planning programs must address the gender dimension in service provision. (Wegs, Creanga, Galavotti & Wamalwa, 2016). Use of family planning is powerfully shaped by social norms, including perceived acceptability of family planning, social pressure for large families, and perceived opposition to family planning by religious and community leaders and spouses. Rigid gender roles and unequal power between men and women inhibit couple communication and joint decision-making about family planning: power

dynamics in couples have been found to influence the use of family planning and other health services (Lusey, San Sebastian, Christianson & Edin, 2018).

Men's perceptions of family planning in Canada are manifold. Their knowledge about contraception is poor and sometimes misconceived (Adams & Mikesell 2017). Preferences regarding a child's gender are strong, thus attitudes and cultural beliefs that might hinder family planning have to be considered. A policy on male contraception and contraceptive services is seen as necessary. (Wambui, Ek & Alehagen, 2019). Modern methods were thought to give side effects, discouraging family planning. Low instances of family planning were also because of the fact that culturally; children are considered wealth. A law advocating family size limitation was regarded as necessary for the future.

In Malaysia, perceived reasons for low use of family planning methods include couples desire for many children, religious and traditional beliefs, myths and lack of correct information about contraceptives (Msoka, Brownie & Holroyd, 2019). Low involvement in modern family planning methods is a barrier for the overall success in reproductive health services, with this attributed to men's opposing roles of being the head of the house and needing to demonstrate virility (Msoka et al., 2019). Women perceive those men contribute to low utilization of family planning and relate this to gender norms that prioritize the role of childbearing and child-rearing for women and men's need to produce many children to signify virility and fulfil religious requirements (Laird, Clarke & Stein, 2020).

In Jordan, low male participation in family planning is considered as one of the obstacles to quality reproductive health care delivery (Adelekan, Omoregie & Edoni, 2019). However, any discussions of men's involvement in family planning must

include their views on ideal family size. Men's fertility preferences play a major role in men's perception of the importance of family planning and the need for reproductive health services (Mansour et al., 2016). In Jordan, the Higher Population Council reported that men and women prefer male children, and that Jordanian families believe that more male children reflect a man's virility and authority. Therefore, the desire to have a male child was found to be an obstacle to family planning programmes (Adelekan, Omoregie & Edoni, 2019).

1.2.2 African Perspective on Perceptions on Use of Family Planning

In Sub-Saharan Africa, Women's participation in domestic decision-making is increasingly being recognized as affecting their ability to use family planning the influence of gender-based power dynamics in sexual relationship between Menand women on reproductive outcomes is becoming increasingly recognized. The empowerment of women as reflected in their socio-economic and employment status, educational levels, household organization, the dynamics of their marital relations and their involvement in domestic decision-making is an important factoring the decline of fertility levels in developing countries.

In Nigeria, the use of any method of FP by women is often influenced by their husbands (Moronkola, Ojediran & Amosu, 2016). Men have rarely been involved in either receiving or providing information on sexuality, reproductive health, or birth spacing. Men have also been ignored or excluded in one way or the other from participating in many FP programmes as FP is viewed as a woman's affair. Traditionally, men are the heads of households and decision makers in all issues in their respective households. Men decide on FP and the number of children as well as how to use what is produced by the family (Silwal & Neupane, 2018). Men were

perceived as the sole providers for their family needs. Women were not considered decision makers, but implementers of what had been decided by men, without questioning men's decisions (Jacobs & Kes, 2015).

1.2.3 Kenyan Perspective on Perceptions on Use of Family Planning

In Kenya, the problem of population growth may not only be seen from an economical point of view. The high fertility rates, which account for the rapid population growth, have serious consequences for maternal and infant health. Short intervals pregnancy and many pregnancies and deliveries pose a large den on maternal health (Catalano & Shankar 2017). Inadequate periods to recover strength between each pregnancy, as well as many deliveries, all associated with different levels of risk, are factors that make high fertility rates a threat to women's health. Moreover, infant health is also plagued by the short interval between births, because short birth interval is associated with increased risk of pre-term births, low birth weight and infant mortality (Molitoris, 2016).

In the recent past the idea that it is significant to understand the socio-cultural contexts in demographic studies has gradually expanded the total population in Kenya that was last recorded at 43.2 million people in 2012 from 8.1 million in 1960, changing 432 percent during the last 50 years. According to the report, Kenya is experiencing a fast-growing population in Africa (Kenya National Bureau of Statistics, 2019).

In Elgeyo Marakwet County, the contraceptive prevalence rate stood at 55.2% compared to the national rate which was 59.7% (Kenya National Bureau of Statistics, 2019). The study was conducted among the Marakwet community in Koibarak location, Elgeyo Marakwet County, Kenya, since there is low uptake of family

planning. This region is mainly inhabited by the Marakwet who are believed to be deeply rooted in their traditional practices. Such practices may have a negative impact on the family planning as some perceive family planning as a practice which should not be adopted. It should be noted that the Government of Kenya has put a lot of emphasis on family planning but these efforts have borne little fruits which has been as a result of families being resistant to family planning methods (Butto & Mburu 2015). This study therefore sought to examine the gender usage differences and perceptions of family planning among Marakwet community as there is limited information on the gender perception, adoption and usage of various FP methods.

1.3 Problem Statement

Various studies have mentioned the importance of men's role in reproductive health and their influence on the decision-making and behavior related to reproduction Ganle, Obeng, Segbefia, Mwinyuri, Yeboah, and Baatiema (2015), Arousell and Carlbom (2016). However, many family planning programs have focused mainly on women. Even though men are increasingly being "involved" by reproductive health programs, their view still seems to be peripheral and problematic (Tilahun, Coene, Temmerman & Degomme 2015). A gender difference between husbands and wives in fertility desires; husbands were more pronatalist than their wives in Ethiopia (Greene, 2000). Short and Kiros (2002) studied husband-wife communication related to family planning and contraceptives in Kenya. It was reported that the wife's perception of her husband's approval of family planning has a significant impact on the current contraceptive use.

The result shows that men’s opinion and perception regarding reproduction have a strong impact on women’s perception and their subsequent behaviour Okigbo,

Speizer, Corroon and Gueye (2015). Women have been given more attention as far as family planning programmes are concerned yet men have an influence on decision making on family planning adoption and usage within household. The question then is: does marginalization of men on family planning programmes hamper the efforts on family planning? This study was therefore conducted to understand gender-based perceptions on the use of family planning among the Marakwet community.

1.4 Research Objectives

1.4.1 Broad Objective

The broad objective of the study was to investigate gender-based perceptions on use of family planning among Marakwet community in Koibarak location, Elgeyo Marakwet County, Kenya.

1.4.2 Specific Objectives

The study was guided by the following objectives:

1. Examine perceptions of family planning methods between men and women of Marakwet community in Koibarak Location.
2. Identify perspectives of men and women on the use of family planning in Koibarak Location.
3. Establish the perceived challenges faced in relation to usage of family planning methods from the gendered perspective in Koibarak Location.

1.5 Research Questions

The study answered the following questions:

1. How are family planning methods used between men and women among Marakwet community in Koibarak location, Elgeyo Marakwet County, Kenya?

2. How do men and women communicate in relation to family planning methods among Marakwet community in Koibarak location, Elgeyo Marakwet County, Kenya?
3. What are the challenges faced in relation to usage of family planning methods between men and women among Marakwet community in Koibarak location?

1.6 Assumption of the Study

The study was based on the following assumptions:

1. Male are discriminated and are being overlooked in the process of family planning programmes
2. Various family planning programmes have been adopted by couples in the study area
3. There is high level of awareness on the use of various family planning methods

1.7 Justification of the Study

According to World Population Prospects (2019) the population in Kenya is currently approximated at 52,648,999 million which is worrying. In order to achieve vision 2030, reduction of high population rate is key among the agenda of the government through influencing people to adopt and use family planning programs and this should be approached with a gender dimension. However, this has not been an easy task particularly by the government as majority of the population especially from rural areas declining to adopt these family planning techniques.

This is marred by traditional and cultural beliefs as well as perceptions that have no scientific basis particularly on the effects of family planning methods. The current study examined and documented how both men and women perceived the usage of

family planning. In addition, no study known to the researcher has been conducted on the gender usage differences and perception on family planning, thus, the current study provides vital information to the residents, researchers, the government, non-governmental organizations and other actors in enabling the attainment of Vision 2030.

1.8 Significance of the Study

Findings and recommendations of this study are vital in assisting the government to identify the gaps in the family planning programmes and therefore generate sound policies that can cater for family planning among couples equally. This study provides a great source of knowledge especially to the male and females who use family planning methods. The in-depth information regarding family planning adoption and usage is crucial for couples in making informed decisions regarding family planning while avoiding the challenges.

1.9 Scope and Limitations of the Study

1.9.1 Scope of the Study

The study was conducted in Koibarak which is found in Elgeyo Marakwet County. It generally assessed the gender-based perception on the use of family planning methods with specific consideration to the following: the level of usage of family planning methods, level of communication between couples and the challenges faced in relation to usage of family planning.

1.9.2 Limitations of the Study

The topic on reproductive health is viewed as sensitive by some respondents which could result to unwillingness to participate in the study by some respondents and dishonest responses by others. To address this problem, the researcher created rapport

with the respondents and assured them of confidentiality that information being collected was purely for study and is important for policy making about men and women reproductive health issues. Also, the researcher ensured that interview items were structured in such a way that respondents were comfortable to give responses without feeling that their privacy is being intruded.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature from other scholars which is related to the current study. The review has been done in relation to the following themes: perception of family planning methods, communication on family planning between couples and the health belief model.

Family planning is identified as the solution to control fertility rates against the rapid population growth. Subsequently, family planning has been expanded in developing countries by each national government, international organizations and non-governmental organizations (NGOs) (Keyonzo et al., 2015). In the 1960's, the organizations related to provide family planning, for instance United Nations Population Fund (UNFPA) and United States Agency for International Development (USAID), were established in response to the problem of the population growth. There has been an emphasis on increasing the use of contraceptives. These organizations, the international society and national governments have regarded long-term methods such as intrauterine device (IUD) as the most effective methods to achieve the demographic goal, which is to reduce fertility rates (Keyonzo et al., 2015). Between the 1960's and the 1980's, declining fertility rate has been diffusing in developing countries, the exception being sub-Saharan Africa (Pillai & Wang, 2018).

2.2 Perception of Family Planning Methods

Many sub-Saharan Africa countries have high rates of unmet needs for family planning (FP) and low rates of contraceptive use. Individuals and couples, who want

to limit their fertility, are often unable to obtain the FP methods they need due to numerous barriers (Ochako, Mbondo, Aloo, Kaimenyi, Thompson, Temmerman & Kays 2015).

These barriers include high cost, long distances, poor distribution, medical restrictions and fear of side-effects, or even misinformation. The lack of understanding surrounding what influences FP use and how decision making takes place in families has led to the inability of policy and programs to focus on the factors that are most important to helping people control their fertility (Gure, Dahir, Yusuf & Foster, 2016). Although much of the available literature assumes that financial cost is the primary factor inhibiting contraceptive use, various studies around the world suggest that fear of side - effects of FP are more influential in decision-making (Rashid, Sohail & Munim, 2017).

It is estimated that 59% of unintended pregnancies could be eliminated if method-related reasons for non-use were overcome; and fear of side-effects is the most commonly cited reason for such non-use. For instance, in the Colombia 2015 Demographic and Health Survey (DHS), 21% of married women with unmet need for FP cited health problems or side-effects as their reason for non-use, while 10% cited cost/access and none cited lack of knowledge (Svallfors & Billingsley, 2019). Also, the 2001 Uganda DHS found that 25% of married female non-users cited health/side-effects as the reason for non-use, 20% cited cost/access, and 5% reported lack of knowledge. Similar trends were established in Asia, South America and Africa (Alege, Matovu, Ssensalire & Nabiwemba 2016)).

Fear of side-effects is also a commonly cited reason for contraceptive discontinuation. Many studies have found that while some of these are based on actual health related

side-effects, many fears are based on rumours, rather than personal experience (Gueye, Speizer, Corroon & Okigbo 2015). A study in Nepal found that side effects were the main reasons cited for discontinuing the use of FP and that most people received information about FP from mass media (Mattebo, Sharma, Dahlkvist, Molinder & Erlandsson 2016).

In Nigeria, knowledge of FP is generally high; however, use remains low. The main reasons for this lack of FP use include fear of complications, lack of understanding of methods and fear of opposition from the husband. Diamond-Smith, Campbell and Madan, (2012) identified evidence of fear of FP side effects among females and males from India, Nepal and Nigeria. Furthermore, fear of side-effects from hormonal methods among male partners has also been found to impact females FP decision-making and their fear to use FP (Schwandt, Skinner, Hebert & Saad 2015). Generally, researches show that spousal communication can increase contraceptive uptake and continuation.

Moreover, it is clear that spousal discussion and partner approval are significant in inducing a woman to use modern contraceptives in the Central Terai region of Nepal (Wasti, Simmons, Limbu, Chipanta, Haile, Velcoff & Shattuck 2017). Determinants of spousal communication are varied and complex. In Sub-Saharan Africa, gender roles and norms are particularly salient, shaping spousal communication and subsequent FP decision-making in significant ways. Although contraceptive methods and services are frequently geared toward women, men are often the primary decision-makers on family size and their partner's use of FP methods.

In addition, spousal disagreement can serve as deterrent because women might fear initiating a difficult conversation about FP. On top of that, evidence suggests that

communication between couples may influence FP method choice and frequency of use among women already using contraception (Bulatao, 2019). Despite the clear association between spousal communication and contraceptive use, little is known about how communication dynamics influence family planning decision-making.

Dereuddre, Van de Putte and Bracke (2016) in their study noted that there is need to understand the content and pattern of decision making around contraceptive use among couples, and how women and men perceive this process in the context of their relationship. Opposition from male partners has been cited as an important factor that affects FP use (Withers, *et, al.,* 2015). In Ghana for example, ancestral customs give men rights over women's procreative power (Dalaba, *et, al.,* 2016). In fact, women in poorer countries with lower levels of education show the highest rates of unmet needs for FP. In addition, men have traditionally been portrayed as either explicitly or implicitly unconcerned or unknowledgeable about reproductive health. Generally, men have been regarded as formidable barriers to women's decision-making about fertility, contraceptive use and health care utilization (Tao, Onono, Baum, Grossman, Steinfeld, Cohen & Newmann, 2015).

Women's participation in domestic decision-making is increasingly being recognized as affecting their ability to make reproductive decisions. Demographic literature suggests that active involvement in domestic decision-making indicates the power of women within the household and, consequently, their ability to control their fertility (Colfer, *et, al*. 2015). Several studies have found that woman with little autonomy in the household are less likely to make innovative decisions.

The influence of gender-based power dynamics in sexual relationship between men and women on reproductive outcomes is becoming increasingly recognized (Mandal,

Muralidhara & Pappa, 2017). The empowerment of women as reflected in their socio-economic and employment status, educational levels, household organization, the dynamics of their marital relations and their involvement in domestic decision-making is an important factor in the decline of fertility levels in developing countries. This connection between paid employment and demographic behaviour has been found to be strong, particularly in its impact on contraception and fertility (Wegs *et al*., 2016). The rationale behind this connection is that the financial contribution to the household by women with paid employment is higher, hence enabling them to control resources and household expenditures, as well as their reproduction (Tilly & Scott, 2016).

As family planning programs challenge complex societal norms, they may also challenge traditional gender roles and dynamics and reshape social norms, for example, by endorsing women's right to refuse sex, and by encouraging couples to discuss and jointly decide on an appropriate contraceptive method (Chant, 2017). In Tanzania at 5.4 the Total Fertility Rate (TFR) is still high. Currently, 34% of married women in Tanzania use some method of contraception. Of these, 27% use a modern method and 7% use traditional methods. The most commonly used methods among married women in Tanzania are injectables, pills and female sterilization (Nakao, 2015).

Between 1991 and 2010, five nationally-representative surveys have measured contraceptive use among currently married women in Tanzania. The surveys show that during the last 19 years, there has been a gradual but steady increase of contraceptive use among currently married women, from 10% in the 1991–92 Tanzania Demographic Health Survey (TDHS) to 34% in 2010. In addition, the use of

modern contraception methods increased by 20 percentage points, from 7% in 1991–92 to 27% in 2010.

The Contraceptive Prevalence Rate (CPR) has increased from 26% of married women in 2004–05 to 34% in 2010. Furthermore, the current use of modern (current) contraceptive methods among all women has increased from 18% in 2004–05 to 24 percent in 2010 (Nakao, 2015). Despite the ready availability of FP methods and high contraceptive knowledge, the use of FP methods remains low. It is not well-established how people make family decisions on FP use. Neither have their perceptions on FP been well established. These are important issues to be addressed so as to enhance further contraceptive use and lower fertility levels in the East African countries.

The rapid population growth has been identified as a problem by national governments and the international society (Coale & Hoover, 2015). This phenomenon, which causes for example shortage of cultivated land and unemployment, are claimed to cause increasing poverty and environmental stress (Simon, 2019).

However, the problem of population growth may not only be seen from an economical point of view. The high fertility rates, which account for the rapid population growth, have serious consequences for maternal and infant health. Short intervals pregnancy and many pregnancies and deliveries pose a large burden on maternal health. Inadequate periods to recover strength between each pregnancy, as well as many deliveries, all associated with different levels of risk, are factors that makes high fertility rates a threat to women's health. Moreover, infant health is also plagued by the short interval between births, because short birth interval is associated

with increased risk of pre-term births, low birth weight and infant mortality (Klaus, 2019).

During the 1950's and 1960's, it has been important for national and international societies to control populations. Since that period the population growth has been treated as a problem, and issues surrounding reproduction, that once were considered the most private to talk about, have become matters of intense public concern (Kost & Lindberg, 2015).

2.3 Gendered based perspective on Family Planning.

Some studies have mentioned the importance of the role of men in reproductive health and their influence on the decision-making and behaviour related to reproduction (Prata, Bell, Fraser, Carvalho, Neves & Nieto-Andrade 2017). As mentioned, many families planning programs have focused mainly on women. Even though men are increasingly being "involved" by reproductive health programmes, the view of men still seem to be that they are peripheral and problematic (Raj *et al*., 2016).

A study by Rusibamayila *et al*., (2017) on fertility preferences and demands for contraception in a family setup indicate a gender difference between husbands and wives in fertility desires; husbands were more pro-natalist than their wives. Basten and Jiang (2015) studied husband-wife communication related to family planning and the use of contraceptives in Kenya. The authors reported that "the wife's perception of her husband's approval of family planning" (Basten & Jiang, 2017) has a significant impact on the current contraceptive use. The result shows that men's opinion and perception regarding reproduction have a strong impact on women's perception and their subsequent behaviour. Therefore, it is important to study both gender's perception related to reproductive health and more so on family planning, as well as

the communication between wife and husband, in order to understand what factors, shape their behaviour.

2.4 Establish the Gendered Perceived Challenges to Modern Family Planning.

There are various challenges that affect modern family planning. Even as more attention is paid to expanding and ensuring access to family planning services, the measurement of barriers to family planning has been underdeveloped (RamaRao & Jain, 2015). Much of the previous research in public health has focused on only a single dimension of access, whether geographic or physical. While evidence confirming the relevance of geographic proximity to family planning services is widely available, it has long been agreed that access is a multi-dimensional concept and that other factors besides distance likely play an important and influential role in contraceptive access and use.

Cleland and Machiyama (2015) in their study of Punjab articulated six categories of barriers to family planning: the strength of motivation to avoid pregnancy, knowledge of contraception, costs of practicing contraception (including perceptions of social, cultural, and religious costs), husband's opposition to family planning, health concerns about contraception, and inadequate access. Two other notable studies have each developed an explicit framework for reasons behind unmet need for family planning. In their study of the Philippines, Ozaki *et al*., (2017) outlined two potential explanations for observed levels of unmet need. The first concerns measurement; namely that surveys may not be able to capture the full range and strength of fertility intentions or of intermittent family planning use. The second includes barriers to family planning use: ambivalent fertility preferences, perceived infecundity, and lack of knowledge of family planning, social and cultural unacceptability of family

planning, fear of health effects, inadequate services, and opposition from husband, relatives, and community members. Based on a review of the literature and an expert review meeting about the causes of unmet need, Machiyama et al. (2017) developed a framework that classifies the causes of unmet need into five categories: weak, inconsistent, or ambivalent fertility preferences; generic disapproval of pregnancy prevention; method-specific barriers to contraceptive use; perceived low risk of getting pregnant and partner-related factors.

2.5 The Health Belief Model

The Health Belief Model (HBM) is a model that attempts to explain and predict health behaviour (Becker, Drachman, and Kirscht, 1974) by focusing on individual beliefs, perceptions and attitudes. The HBM has been developed to encompass solutions to practical problems in public health services, and was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services (Rosenstock, 1974).

This research will embrace the Health Belief Model (HBM) developed Strecher and Rosenstock in (1997). In order to elaborate and predict the preventive health behavior a health belief model was developed to curb this systematically. Its main aim was to explain the correlation between health behaviors, practices and consumption of health services. Ideally the model was developed to help individuals to get the reason as to why people do not embrace ways of preventing diseases or screening modes for the finding the diseases at stages that can be managed.

The constructs are highlighted below;

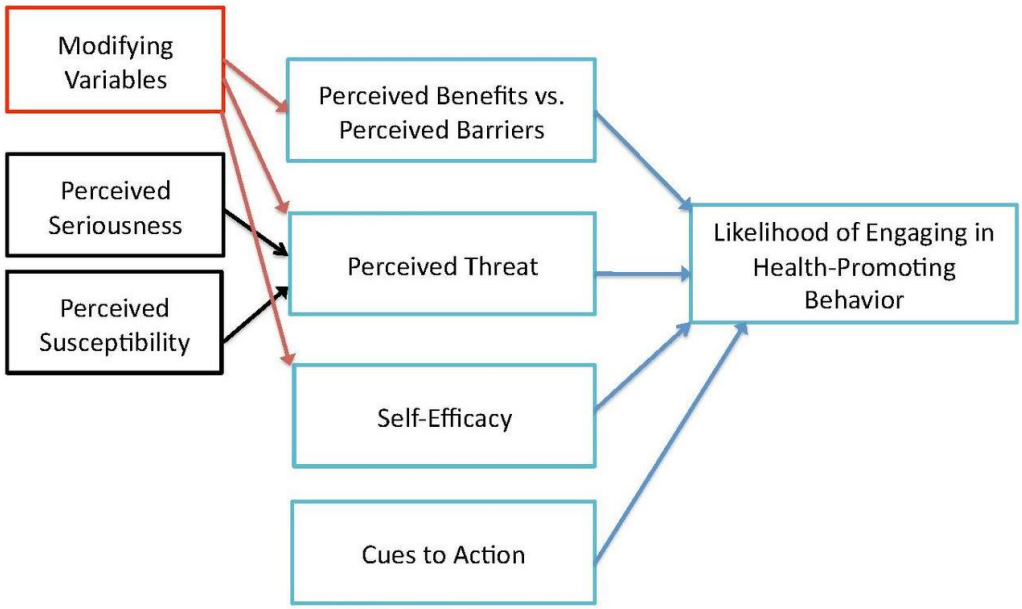


Figure 2.1: Health Belief Model

Source: Strecher and Rosenstock (1997)

Perceived severity – This is how an individual feel about the seriousness of acquiring a disease (or living without treating the disease, basically leaving the illness untreated). Differences do exist in an individual perception of severity, and normally an individual pays attention to the final medical results (Such as permanent disability or even death) and the social effects that come with it (for instance, the effects it has on family life and normal social interaction) when assessing the seriousness (De Gucht, 2015).

Perceived benefits - This refers to an individual's belief of how the different available procedures curb or reduce the effects a disease (the perception to treat an illness). How an individual reacts to cure or try and stop an illness vary depending on the individuals' perception of susceptibility and the perceived benefits, such that the

individual may only accept the available recommendation, if the procedure is perceived to be beneficial (Bhatti & Rehman, 2020).

Perceived barriers – These are the challenges that may stop an individual from undergoing the recommended health procedures. There are various factors that lead to personal impediments, which in turn lead to a cost/benefit analysis. The individual finds out the effectiveness of the procedures and weighs them against the feeling that it might be costly, or may affect them by having painful side effects, that are irritating and unpleasant to live with, takes a lot of time, or may not fit their schedule (Jones, et al., 2015).

Cue to action –The process of accepting and implementing a recommended health procedure may require some stimulus to trigger them. Such cues may be inbuilt (for instance, wheezing or chest pains) or may be due to external forces (such as, taking advice from close family members, illness of immediate relatives, published newspapers) (Green & Murphy, 2014).

Self-efficacy – It is regarded as the individuals' self-esteem (personal believe) to implement a behavior successfully. This variable was included in the model in mid-1980. Self-efficacy is an establishment in most behavioral theories, because it directly relates to whether an individual achieves the recommended behavior (Hajian-Tilaki & Auladi, 2014).

HBM has various shortcomings that may affect its use in public health. These shortcomings include: It does not consider an individual's attitudes, perceptions, or any other personal factors that affects the acceptance of a health behavior; HBM does not factor in behaviors that are always done, therefore, may persuade the decision-

making process to go along with a recommended action. It does not consider behaviors which are conducted for non-health related purposes like social sufficiency. It does not consider the prevailing environmental conditions that might derail or foster the recommended action. It presumes that each individual is equipped with the same amount of information about a particular disease. It also assumes that cues to action are effective in persuading people to act and that "health" actions are major objectives in decision-making process (Sulat, et al., 2018).

HBM does not propose a way for modifying health-related actions. In pre-emptive health behaviors and thus, it's more of illustrative than explanatory, previous research revealed that anticipated susceptibility, benefits, and impediments were constantly related with the desired health behavior; perceived severity was rarely linked with the recommended health behavior. Personal establishments are important, depending on the health results of interest, but for a model to be effective this construct should be fused with other models that put into consideration the prevailing environmental conditions and propose strategies (master-plans) for change (Raheli, Zarifian & Yazdanpanah, 2020).

Broadly spoken, the model illustrates that there will be some predisposing factors that together with certain enabling and supportive factors will lead people in different directions when they make choices related to how they are to treat their illness. Predisposing factors involve health beliefs and attitudes towards the illness, the related treatment, as well as the health services. The health beliefs people hold include general health beliefs such as how "health" in general is perceived and willingness to seek help based on a certain medical direction/treatment. It also includes more

specific health beliefs such as perceived susceptibility to the disease, belief in the diagnosis, and perceived severity of the condition (Rosenstock, 1974).

The other main constructs that constitute the HBM is “perceived barriers”, which is an individual's assessment of the factors that discourage a certain health related behaviour, whereas “perceived benefits” are an individual's assessment of the factors that are seen as a positive consequence of adopting a certain behaviour. At a later stage the HBM included certain modifying factors such as demographic variables (like sex, age, ethnicity, occupation), socio-psychological variables (like socio-economic status, coping strategies), and “cues to action” (information provided by powerful others, personal experiences) (Becker, 1990; Rosenstock, 1974).

This means that perceptions and experiences of for example sociocultural factors or direct or indirect economic costs related to the behaviour are all influential. The combination of different factors will continuously be interpreted and evaluated and subsequently the “sum” of perceived negative and positive aspects of treatment lead people in different directions, making different choices related to their health.

This study presupposes perceptions related to family planning and reproduction to be an important factor which affects contraceptive use. The Health Belief Model emphasis on health beliefs fits this presupposition in the sense that it draws attention to people’s beliefs which the study regard as central in understanding behavioural varieties related to family planning.

2.6 Study Gaps

There have been a number of valuable studies on perceptions on the use of family planning, the majority of which majors on developed countries and African countries

outside Kenya. The review of the literature revealed the gender-based perceptions on the use of family planning among women. Studies that have been carried out in Kenya have not focused on this study's main objectives: Gendered perspectives, challenges, and health beliefs of use of family planning. Therefore, another knowledge gap that was addressed by this study in an attempt to add to the body of knowledge is to give the research a Kenyan perspective. In order to fill this gap, the current study needed to fill the existing research gap by investigating the gender-based perceptions on the use of family planning among the Marakwet community in Koibarak location, Elgeyo Marakwet County, Kenya.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter entails the methods that were adopted during data collection. It has been divided into various sections. These include; the study area, study design, study population, sample size determination, sampling procedure, data management, data analysis and ethical issues.

3.2 Study Area

The study was conducted among Marakwet community in Koibarak location, Elgeyo Marakwet County, Kenya (Appendix VI). Elgeyo Marakwet County is located in the former Rift Valley Province with Iten town as the head quarter. It borders the following Counties: West Pokot to the North, Baringo County to the East, South East and South, Uasin-Gishu to the South West and West, and Trans Nzoia to the North West. The County has an area of 3,029.8 km^2 with temperatures ranging from a minimum of 14°C to a maximum of 24°C. The rainfall ranges between 400 mm and 1,400 mm per annum. The County is mainly occupied by the Keiyo and Marakwet. This region is mainly inhabited by the Marakwet who are believed to be deeply rooted in their tradition practices. Such practices may have a negative impact on the family planning as some perceive family planning as a practice which should not be adopted.

3.3 Study Design

According to Yin (2017), a research design is a plan, or structured framework of how one intends to conduct the research in order to address the research problem. It is a program of all the procedures that guides the researcher in collecting, analysing and

interpreting data. Research design is considered as a blueprint for research. The study adopted qualitative method.

The study adopted descriptive survey design in assessing the gender-based perceptions on use of family planning among Marakwet community in Koibarak, Elgeyo Marakwet County. The design was considered appropriate due to its flexibility nature of allowing qualitative data collection and analysis. In addition, the design allowed extensive data collection, determining and reporting the way things are in their natural setting without manipulating any variables (Bryman, 2011).

3.4 Target Population

Kellstedt and Whitten (2018), describe population as the entire set of individuals or objects, having some common characteristics that are of interest to the researcher. The population of the study was 8,576 in Koibarak Location (Elgeyo Marakwet County Annual Development Plan 2017/2018). A target population comprises of a sample or studied cases as well as the unstudied cases (Queirós, Faria & Almeida 2017). The study targeted men and women who are in a position of using various family planning methods and have children (Elgeyo Marakwet County Annual Development Plan 2017/2018). The population was chosen because they were in a position to give their opinions on the perceptions from a gendered based perspective. In addition, since the study was gender based, both male and female were considered to understand the different opinions and perceptions.

3.5 Inclusion and Exclusion Criteria

3.5.1 Inclusion Criteria

- Married couples having either one or more children.
- Those who consented

3.5.2 Exclusion Criteria

- Those who did not consent

3.6 Sample Size and Sampling Techniques

3.6.1 Sample Size

Samples for qualitative studies are generally much smaller than those used in quantitative studies. Bujang, Omar and Baharum (2018) state that there is a point of diminishing return to a qualitative sample known as saturation point where according to them, as the study goes on more data does not necessarily lead to more information.

Therefore, the required sample size was 87 participants comprising of 27 respondents who participated in interview schedule and 60 respondents participating in focus group discussion. The criteria used to select 27 respondents for interviews was purposive as per the households in each village. The three villages had been convened by a locational Barraza and therefor were found at the same location at the time of the study.

3.6.2 Sampling Procedure

The study used cluster sampling because the target population was mutually homogeneous yet internally heterogeneous groupings are evident. The target population was divided into clusters/groups (three villages) making up Koibarak Location and a simple random sample was used to select participants from each cluster (village). This sampling techniques was used because the researcher could not get information about the population as a whole, but got information about the clusters. The researcher compiled data from selected clusters and compile them to get a picture about the location. The individual villages were the clusters in this case. Cluster sampling was important in this study because it allowed selection of only

married couples from the entire population. The method required fewer resources for the sampling process. Therefore, it was generally cheaper relative as it requires fewer administrative and travel expenses.

Data collection was carried out with the help of area chief and nine village elders who called for meetings where researcher conducted the interviews and FGDs. Area chief and village elders were briefed about the study early enough in order to call for the meetings per village on different days. It offered researcher the opportunity to interview several respondents systematically and simultaneously.

3.7 Data Collection Methods

Based on the nature of data to be collected and the objectives of the study, this study employed the use of in-depth interviews using an interview guide and focused group discussion schedule.

3.7.1 Interviews

The in-depth interview schedule was selected because of three reasons. First, it helped to verify the reliability of the information gathered by the focus group discussion. The technique is useful in checking in-depth information that cannot be found in other methods. Yates and Leggett (2016) noted that presenting questions orally is a particularly appropriate means of gathering information from the less educated group in Elgeyo Marakwet, with most of the respondents having attained primary school education. The approach created confidence on the part of the respondents and as they gain interest on the subject, more reliable, valid and objective results were obtained.

Interviewing method was used to collect information from the respondents. An interview schedule which is a set of questions that the interviewer asks when

interviewing helped the researcher in ensuring that only relevant information is collected (Malterud, Siersma & Guassora, 2016). The researcher conducted interviews on married couples from Koibarak regarding gender-based perception on family planning. Interview schedules are structured, to reflect attributes of perceptions which entail knowledge, attitudes and attitudes. These attributes have been reflected against each question. See Appendix [11, page 82] Interviewing nature of the interview schedule allowed for specific information to be sought from the respondents. In addition, this structured interview schedule was preferred because the researcher feels it created a more structured information to be collected.

Table 3.1: Interview Guide (See appendix 2)

Questions	1	2	3	4	5	6	7	8
Perspective								
Attitude	✓			✓		✓	✓	✓
Knowledge						✓	✓	✓
practice		✓	✓		✓	✓	✓	✓

3.7.2 Focus Group Discussion

Focus group discussion is a form of group interview where a researcher or a moderator facilitates a discussion with a small group of people on a specific topic (Guest, Namey, Taylor, Eley & McKenna 2017). It combines both elements of individual interviews and participant observation (Gawlik 2018). Focused group discussions were done on five groups with 8-12 members among some of the 60 respondents. One group consisted of only married female, the other included married men while the other three groups had mixed gender.

The reason for adopting FGD was to provide useful insight into different opinions from both male and female involved identified. It was also used to supplement information which might have been omitted or not clearly established through the

interviews. In addition, the method enabled the researcher to explore the views of the participants and to generate answers to issues, which could have been more difficult in face-to-face interviews. Lastly, this approach reduced the amount of time as it generally yielded detailed qualitative information from a relatively large number of discussants congregated in one place. The group's composition and the group discussion were carefully planned to create a nonthreatening environment. This was to ensure that participants felt free to talk openly and gave honest opinions. The researcher organized five focused groups. In order for one to be included in an FGD, first he/she had to be married and having either one or more children. This enabled the researcher to get views and opinion of both genders. Information was collected with the assistance of the focused group guide.

Table 3.2: Focussed Group Discussion Guide (see appendix 3)

FGD question perspective	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Attitude						✓	✓
Knowledge		✓				✓	✓
practice			✓	✓	✓	✓	✓

3.8 Data Management

Data management is an administrative process that includes acquiring, validating, storing, protecting, and processing required data to ensure the accessibility, reliability, and timeliness of the data for its users. Data was captured using focused group discussion guide as well as interview guide. Using these tools, the researcher solicited qualitative information. Qualitative information was from the interview guides as well as FGDs guides were transliterated and categorized into themes which included levels of usage of family planning, communication adopted and challenges. The themes were general; however, the information was later put into summaries. Data that were

obtained from the study respondents through focused group discussions and interviews was highly protected with no access to unauthorized persons except the supervisors. After data was analyzed, the collected information appearing on interview schedules as well as those recorded were destroyed. Furthermore, a password was enabled to the documents in soft copy in order to avoid intrusion. In addition, data search from journals was done based on the study themes such as the level of gender usage of family planning, family planning communication strategies and challenges faced in using different family planning methods.

3.9 Data Analysis, Interpretation and Presentation

Thematic analysis entailed identifying, analysing, and reporting patterns (themes) within data. Analysis of interviews and focused group discussion were done through thematic analysis. After conducting the interviews from the respondents, the researcher familiarised herself with the data through reading and re-reading. This was then followed by the researcher making notes and jotting down early impressions which was useful. Then, generation of initial codes followed. In this phase the researcher organised her data in a meaningful and systematic way. It is worth noting that coding reduces lots of data into small chunks of meaning. Further, the researcher was concerned with addressing specific research questions and analysed the data with this in mind. For instance, in this study, the researcher was focused on level of usage of family planning according to gender, communication ways among married couples and challenges facing family planning methods. This was followed by searching for themes with broader patterns of meaning. For instance, data was repeatedly exposed to analysis until the themes and categories emerging were regarded as satisfactory. In this case we examined the codes and some of them clearly fitted together into a theme. At the end of this step the codes had been organised into broader themes that

seemed to say something specific on a particular research question. The themes were predominately descriptive, that is they described patterns in the data relevant to the research question. The researcher then reviewed themes to make sure they fit the data. The data was then interpreted and presented based on the study objectives.

3.10 Pilot Study

A Pilot Study is a version of the main study that is run in miniature to test whether the components of the main study can all work together. It is a small study conducted in advance of a planned project, specifically to test aspects of the research design (such as stimulus material) and to allow necessary adjustment before final commitment to the design. The non-verbal behaviour of participants in the pilot study provides important information about any embarrassment or discomfort experienced with regard to the content or wording of items in a questionnaire. A pilot study was conducted in Kusrwo Location, neighbouring to Koibarak Location, in order to ensure that data collection tools are consistent and without ambiguities. Through piloting, the researcher organized one Focused Group Discussion of 6 members and 3 interviews representing 10% of the sample population. It was through this piloting exercise that the researcher revealed the weaknesses of her tools. For example, some of the terms used were ambiguous since not all participants understood them equally. Furthermore, it was also determined that some questions were irrelevant and therefore the research had to do away with them.

3.11 Ethical Considerations

To ensure the aforesaid, the researcher obtained verbal consents from the respondents. This was done by the researcher explaining the purpose and objectives of the study to the respondents. They were also informed of the study objectives, methods and its

relevance. They assured of anonymity and confidentiality and no person was forced into participating in the study.

At the same time, the researcher ensured that all respondents and informants are treated with respect and their privacy observed. The respondents were informed that their names were not indicated in the report. The researcher also provided the respondents with her contacts in case they may want to contact her in future. The researcher provided a consent form (See Appendix I) to all participants and they were allowed to sign before being interviewed. This gave consent for the interviews to continue. In order to conform to the standards of conduct of research, the researcher obtained an introductory letter from Moi University. In addition, an approval letter to allow data collection was also obtained from IREC.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results and discussion as organized based on the study objectives. More specifically, this chapter analysed gender-based perceptions on the use of family planning in Koibarak, Elgeyo Marakwet County. Analysis was based on the following three objectives:

1. Examine the perceptions of family planning methods by men and women of Marakwet community in Koibarak, Elgeyo Marakwet County.
2. Identify gender-based perspectives on the use of family planning in Koibarak, Elgeyo Marakwet County.
3. Establish the perceived challenges faced in relation to usage of family planning methods from the gendered perspective in Koibarak, Elgeyo Marakwet County

4.2 Background Information of Participants

Analysis of background was done based on gender, age, level of education as well as the number of children that respondents have.

Table 4.1: Participants in the Study

Gender	**Male**	**Female**	**Total**
n	37	50	87
percentage	42.5%	57.5%	100%

4.2.1 Gender of the Participants Interviewed

A sample of 27 participants were interviewed with 13(48.1%) of them being male while the other 14(51.9%) being female. Figure 4.1 has a summary of the information.

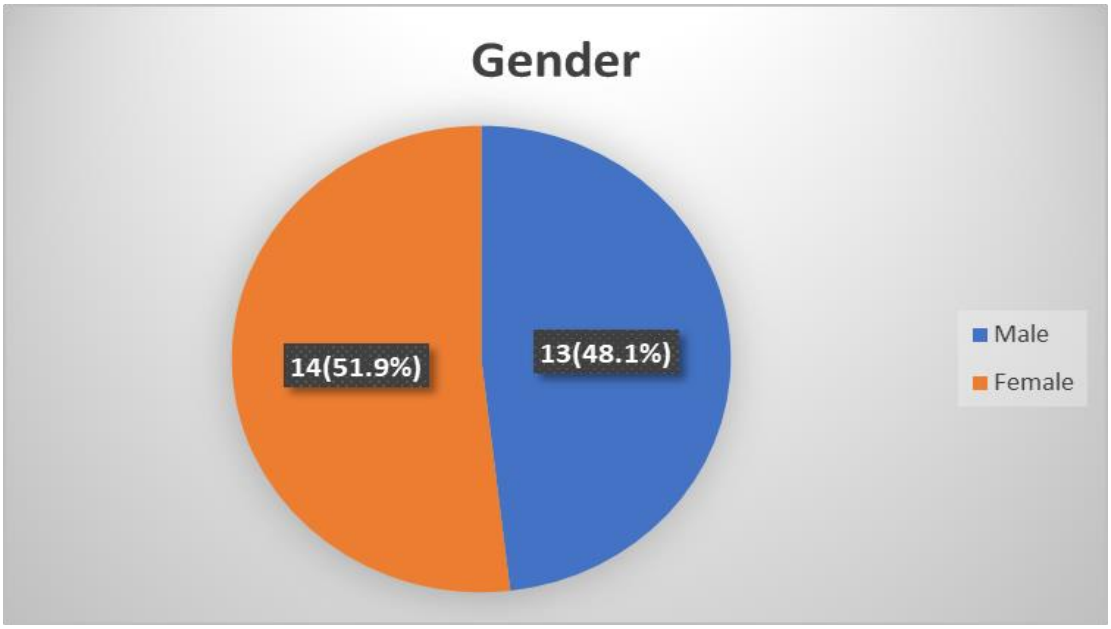


Figure 4.1: Gender of the Participants

Gender of the participants who were interviewed was approximately equal since the study was based on gender perception and therefore representation was vital in order to compare opinions of both genders. Similarly, those who participated in focused group discussions there were 30 men and 30 women.

Table 4.2: Shows Equal Gender Distribution for Each Group

Group no.	Male	Female
1	6	6
2	6	6
3	6	6
4	6	6
5	6	6

4.2.2 Age of the Participants Interviewed

After collecting and analyzing data, age of the respondents was grouped into three categories. The minimum age identified was 22 years while the maximum age recorded was 45 years. Figure 4.2 has a summary of the findings regarding age.

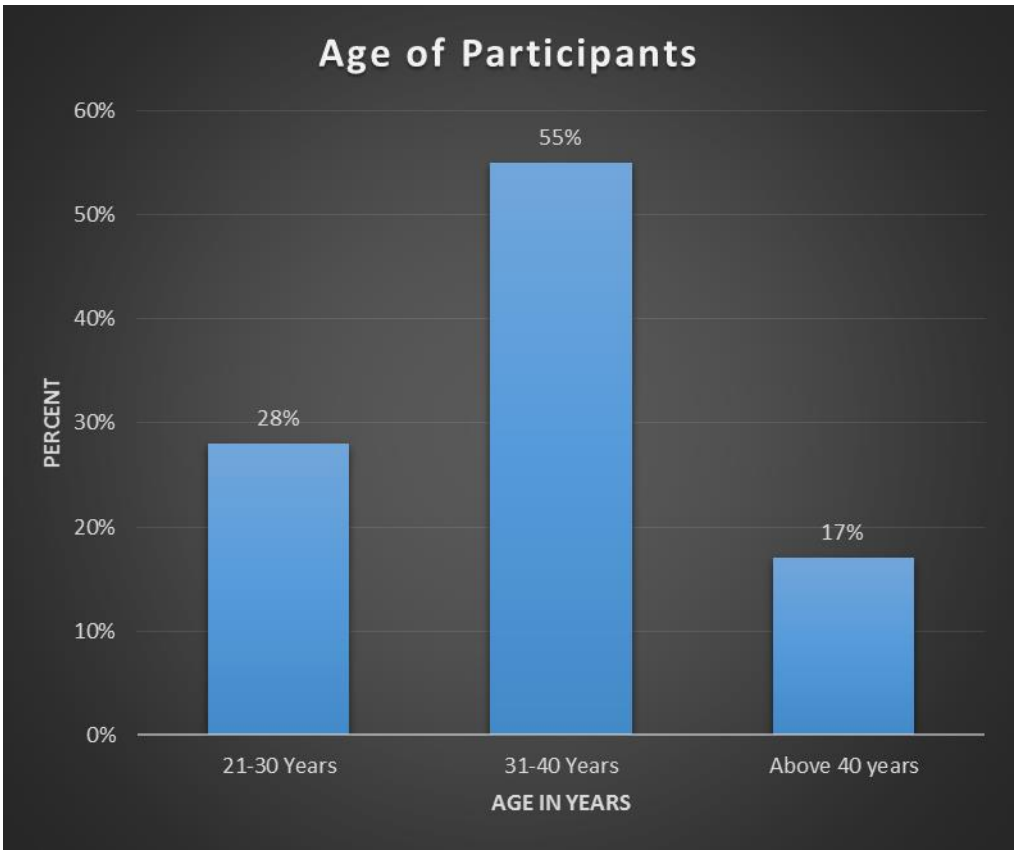


Figure 4.2: Age of the Participants (n =87)

Table 4.3: Age of the participants (Overall)

Age	**21-30**	**31-40**	**+40**	**Totals**
Number (n)	24	44	15	87
percentage	28%	50%	17%	100%

Findings relating to age of participants indicate that majority 15(55%) were aged 31-40 years. It was also established that 8(28%) were aged 21-30 years while 4(17%) were aged above 40 years. It is clear from the study that majority (72%) of the respondents were above 30 years. Age is a very vital factor as far as family planning

among couples is concerned. Different family planning forms may be applied at different ages within child bearing bracket.

In addition, those who participated in FGDs had their ages ranging from 28 years to above 40 years.

4.2.3 Highest Level of Education of the Participants Interviewed

The level of education is very pertinent in terms of influencing first; whether to adopt family planning methods and two; which forms of family planning to adopt. When asked about their highest level of education, majority were found to have primary education as shown in Figure 4.3.

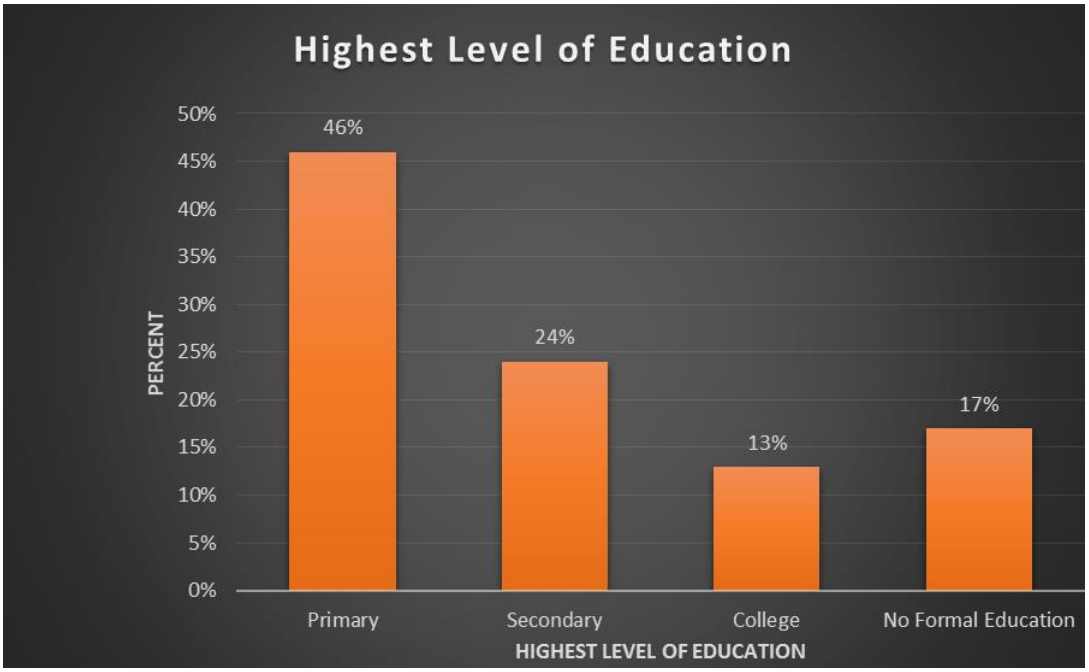


Figure 4.3: Highest Level of Education

Table 4.4: Level of Education

	Primary	Secondary	College	No formal education	Total
Frequency	40	21	11	15	87

In relation to the highest level of education, 12(46%) were found to have primary education, 6(24%) had secondary education, and 4(13%) had acquired college education. Conversely, 5(17%) of the participants were found to have not acquired formal education. Level of education among spouses may influence the choice of family planning adoption. With formal education it is easier to make informed choices because of wide understanding of issues, including health as compared with ones without formal education. With education it is easy to put information delivered by health workers in the right context.

4.2.4 Number of Children that Interviewed Participants Had

Family planning in most cases is emphasized due to the fact that couples bring forth children whom they can be able to manage in order to provide quality living for the family. In order to establish the perceived effect and benefits of family planning among the respondents, the study sought to establish the number of children that each of them had. Figure 4.4 has a summary of the findings.

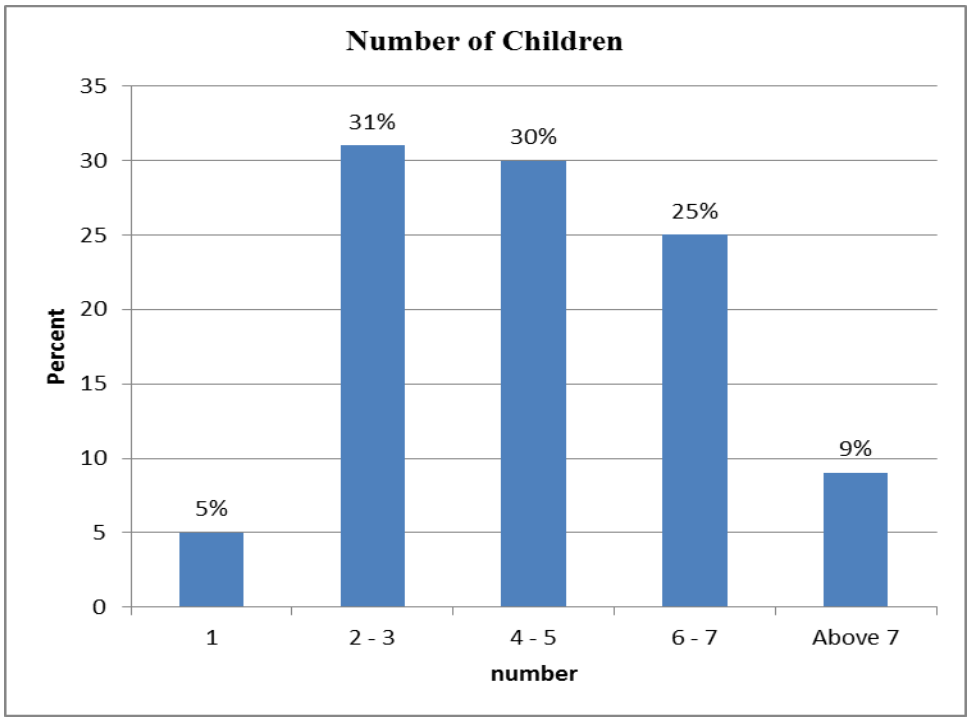


Figure 4.4: Number of Children

Table 4.5: Number of children (for the in-depth interviews)

	Male	Female	Total
Only 1	0	0	0
2-3	2 (7.4%)	10 (37.0%)	12 (44.4%)
4-5	5 (18.5%	7 (26%)	12 44.4%)
6-7	3 (11.2%)	0	3 (11.2%)
Total	**10 (37.1)**	**17 (63)**	**27 (100%)**

4.3 Participants' Understanding of Family Planning

Family planning is the arrangement of when to have children, and the use of birth control and other techniques to implement such plans. Successful family planning efforts is essential in alleviation of global poverty by positively contributing to socio-economic development. Controlling both the number and timing of births through utilization of contraception is associated with improved maternal and neonatal health outcomes hence contributing to the attainment of Sustainable Development Goals (SDGs). When participants were asked to give their own perception on use of family planning, majority said that it is the spacing of children and getting the desired

number of children that one can be able to manage. Family planning is most adopted by couples who wish to limit the number of children they want to have and control the timing of pregnancy, also known as spacing of children. However, some of respondents have different perceptions about family planning.

One of the respondents said that:

> "*This family planning is for the whites which has been adopted by the young generation who do not want many children. But in my take, it is because they do not want to fill the world as well as not able to feed them. However, we want them to bear many children and this is a new thing brought in by other people*."
>
> ……
>
> (**Source: Male respondent, 45 years**)

This means that before family planning, a family used to bear many children as many as they could without even their wish. People who always suffered as a result of these were women because they were left with the whole responsibility of taking care of the children. This always used to be the cause of conflicts among families. This agrees with the study by Lincoln, Mohammadnezhad and Khan 2018) which shows that family planning is identified as the solution to control fertility rates against the rapid population growth. Subsequently, family planning has been expanded in developing countries by each national government, international organizations and non-governmental organizations (NGOs).

One of the key informants reported that:

> *"This family planning helps others because in the past we use to have so many children up to ten but this family planning is helping. If you now get many children, you will not be able to feed them. Your husband will just tell you to bear him children but will not help you raise them. With this family planning a woman is able to plan herself"*
>
> …….
>
> (**Source: Female respondent, 35 years**)

This implies that, most of the young parents and young families agrees to the interventions of the family planning and have appreciated on its importance. This disagrees with the study done by (Doughert, Kayong, Deans, Mundaka, Nassali, Sewanyana & Heil, 2018) who found out that only side effects were the main reasons cited for discontinuing the use of FP and that most people received information about FP from mass media.

Another respondent said that:

> *"Another thing is that this family planning will support our women either financially or any other kind of approval because we have to agree first at home as couples. We discuss on the number of children we want to have"*
>
> …….
>
> (**Source: Female respondent, 34 years**)

This means that, women will have enough time to do other things for income generation other than nursing the children. As a family also the couple have more time to talk of issues of uplifting the family's economy. As a result of these families are in a good position to have peace and harmony. This agrees with the study by Mahapatro (2016) who claimed that empowerment of women as reflected in their socio-economic and employment status, educational levels, household organization, the dynamics of their marital relations and their involvement in domestic decision-making is an important factor in the decline of fertility levels in developing countries. This connection between paid employment and demographic behaviour has been found to be strong, particularly in its impact on contraception and fertility.

One of the respondents reported that:

> *"We encourage them to use family planning so that they are able to get children they are able to educate from baby class to university"*
>
> …….
>
> (**Source: Male respondent, 35 years old, health care worker**)

This means that the government, healthcare workers and all the stakeholder involved should encourage the public on importance of using family planning methods as far as the education of their children are involved and that it is for their own good and advantage. This study agrees with World Health Organization, (2013) whom the claim that, family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings. One of the informants reported that:

> *"This family planning helps others because in the past we use to have so many children up to ten but this family planning is helping. If you now get many children, you will not be able to feed them."*
> ……
> ….
> (**Source: Male respondent, 45 years**)

This implies that in the past, most families had not known the importance of family planning neither had they received the knowledge of family planning. Also, neither was there any consultation and discussion between the couple on either to use the Family planning or not. This disagrees with the study findings by Rogers, et al. (2019) who said that it is clear that spousal discussion and partner approval are significant in inducing a woman to use modern contraceptives in the Central Terai region of Nepal.

Other respondents noted that:

> "*Economy has gone up and children are going to school and you have to pay fees for them, feeding them and attending to their health issues. So, if you do not plan it will be difficult. If you have small children and one gets a cold, all of them will catch the cold*."
> ……
> (**Source: Male respondent, 35 years**)

This means that the economy has risen and families have no option but to use family planning in order to rise children in a good way and feed them well. This can be achieved by having few children according to the much they can earn. This study agrees with study by Farrell, (2017) who found out that after the Second World War the population growth in developing countries reached historically unprecedented rates. Falling mortality due to medical discoveries and continued or even rising fertility turned this population growth into a second population explosion, the first population explosion took place when the industrial revolution started in England in the late 18th century. It led to low standards of living hence necessitated the use of family planning.

4.4 Participants' Understanding of Family Planning (FGDs)

Accordingly, results from focused group discussion revealed that participants knew what family planning was as most of them suggested that it was an arrangement where couples decide the number of children, they want to have for which they can provide quality basic needs. They however voiced their concern regarding the side effects of modern family planning methods.

4.5 Level of Usage of Family Planning Methods from Interviews and FGDs

The first objective of the study was to examine the level of usage of family planning methods between men and women of Marakwet community in Koibarak, Elgeyo Marakwet County. Large numbers of the interviewed respondents were aware of the family planning intervention while few responded to non-awareness.

Table 4.6: Level of Utilization According to Various Demographic Parameters (n=24)

	Use family planning						
	Low	**Moderate**	**High**	**Total**	**X^2**	**df**	**P-Value**
Gender							
Male	4(16.7%)	0(0.0%)	2(8.3%)	6(25.0%)	2.424[a]	2	0.298
Female	7(29.2%)	5(20.8%)	6(25.0%)	18(75.0%)			
Age Bracket							
21-30 years	4(16.7%)	1(4.2%)	2(8.3%)	7(29.2%)	.629[a]	4	0.96
31-40 years	4(16.7%)	2(8.3%)	3(12.5%)	9(37.5%)			
Above 40 years	3(12.5%)	2(8.3%)	3(12.5%)	8(33.3%)			
Education level							
No formal education	3(12.5%)	1(4.2%)	3(12.5%)	7(29.2%)	1.563[a]	6	0.955
Primary education	3(12.5%)	1(4.2%)	1(4.2%)	5(20.8%)			
Secondary education	3(12.5%)	1(4.2%)	2(8.3%)	6(25.0%)			
College education	2(8.3%)	2(8.3%)	2(8.3%)	6(25.0%)			
Children Number							
1 child	2(8.3%)	0(0.0%)	1(4.2%)	3(12.5%)	2.726[a]	6	0.842
2-3 children	3(12.5%)	1(4.2%)	3(12.5%)	7(29.2%)			
4-5 children	3(12.5%)	3(12.5%)	3(12.5%)	9(37.5%)			
6-7 children	3(12.5%)	1(4.2%)	1(4.2%)	5(20.8%)			

The study findings in Table 4.6 revealed that there was no significant association between gender, age bracket, education level, children number and use family planning ($p>0.05$).

The findings from FGDs revealed that majority of them were aware of what family planning methods were. This therefore indicates that residents are aware of the existing of various family planning methods. The knowledge-ability on the existing forms of family planning may influence its adoption. Once couples are aware that there are various family planning methods on the market, they may develop interest and therefore adopt. It is therefore relevant that before one adopts any method of family planning; the information available has a great impact. For instance, it was established that some residents feared to use family planning methods with the belief that the methods are harmful to one's health.

Following the above assertion on family planning beliefs, the study sought to establish the various sources of information on family planning that resident have relied on. As a result, it was established that media advertisements were the major sources of information to residents in relation to family planning. Other sources include: health facilities where health workers pass information to their clients. Peers and friends were also mention during an interview as a source of information of family planning where it was established that after one has tested a certain family planning method, he/she recommends it to her peer or friend.

When asked about the frequency of adoption of various family planning methods, the participants interviewed said that pills are frequently used due to the fact that they are prescribed to be used on a daily basis and more so, it is easier to conceive when need arises. Injections are rarely used since they are long term for instance, an injection can last for a year, two or five depending with one's need. Condoms were also frequently used by men as most female spouses said that they cannot afford female condoms.

Finally, the study found that in most cases, female couples are the one who use family planning methods more than their male counterparts. Due to cultural orientations, male is perceived to be superior and therefore easily decide which method their female counterpart need to adopt.

4.5.1 Types of Family Planning Methods Adopted from Interviews and FGDs

Table 4.7 Types of Family Planning Methods

	Family Planning Methods								
	Pills	**1njections**	**In-plants**	**Condoms**	**Coil**	**Total**	**X^2**	**df**	**P-Value**
Gender									
Male	3(12.5%)	0(0.0%)	0(0.0%)	2(8.3%)	1(4.2%)	6(25.0%)	9.600	4	0.048
Female	1(4.2%)	6(25.0%)	5(20.8%)	3(12.5%)	3(12.5%)	18(75.0%)			
Age Bracket									
21-30 years	2(8.3%)	0(0.0%)	2(8.3%)	2(8.3%)	1(4.2%)	7(29.2%)	9.349	8	0.314
31-40 years	2(8.3%)	4(16.7%)	0(0.0%)	2(8.3%)	1(4.2%)	9(37.5%)			
Above 40 years	0(0.0%)	2(8.3%)	3(12.5%)	1(4.2%)	2(8.3%)	8(33.3%)			
Education Level									
No formal education	2(8.3%)	1(4.2%)	2(8.3%)	1(4.2%)	1(4.2%)	7(29.2%)	4.672	12	0.968
Primary education	1(4.2%)	1(4.2%)	1(4.2%)	1(4.2%)	1(4.2%)	5(20.8%)			
Secondary education	0(0.0%)	3(12.5%)	1(4.2%)	1(4.2%)	1(4.2%)	6(25.0%)			
College education	1(4.2%)	1(4.2%)	1(4.2%)	2(8.3%)	1(4.2%)	6(25.0%)			
Children Number									
1 child	1(4.2%)	0(0.0%)	0(0.0%)	1(4.2%)	1(4.2%)	3(12.5%)	13.03	12	0.367
2-3 children	3(12.5%)	0(0.0%)	1(4.2%)	2(8.3%)	1(4.2%)	7(29.2%)			
4-5 children	0(0.0%)	4(16.7%)	3(12.5%)	1(4.2%)	1(4.2%)	9(37.5%)			
6-7 children	0(0.0%)	2(8.3%)	1(4.2%)	1(4.2%)	1(4.2%)	5(20.8%)			

The study findings in Table 4.7 revealed that there was a significant association between gender and family planning methods χ^2 (4, N = 87) = 9.600, p =.0.048. However, the study findings revealed that there was no significant association between age bracket, education level, children number and family planning methods (p>0.05).

When participants were asked to state the various types of family planning methods adopted, majority of respondents reported that they use modern contraceptives which include the use of pills, injections, in-plants, condoms as well as coil. Conversely, few of the participant still trusts in the traditional of family planning such as prolonged breastfeeding, calendar method and abstinence especially during ovulation period.

The study further found out that adoption of different types of family methods depended on the perception risks that beneficiary attached to these methods. Some for instance reported that injections have adverse effects on one's health and thus, affected their use. According to the participants, the use of modern contraceptives such as pill, condoms help to maintain standards of living, limits the number of children and family as well as reducing expenditure. Others said that family planning makes families small and happy, while others reported that it protects mother's health.

However, other participants said that they were contemplating about abandoning the use of family planning methods since according to them, it has many negative than positive effects. For instance, one participant who is a house wife said;

> '*Nimekuwa nikitumia sindano ya mwako mmoja kama kipanga uzazi lakini sitarudi nyingine tena kwa sababu nimegundua iko na madhara mengi sana. Tangu nianze kutumia mgongo inauma, kichwa na hata kukosa nguvu*' *that I have been using a one-year injection as a way of planning my family but I will not continue using it due to various side effects. Since I started using, I have been having back problem, headache and lethargy.'*
>
> ……
>
> (**Source: Female respondent, 40 years**)

This implies that use of family planning comes with a lot of side effects which has discouraged most of the women from using some of the family planning procedures and the FP at large.

One of the respondents said that:

> *"Here in Koibarak for instance me, I sat and talked with my wife and she started using Depo"*
> …….
> (**Source: Male respondent, 43 years**)

This means that, not all couples accept to use Depo for family planning. It shows that husbands should be the frontline in their families in implementation of family planning. The introduction of the same have resulted to families living in good standards reducing the rate of children not attending school.

One of the informants responded that:

> *"I come from Koibarak and I talked with my wife and we are using family planning and she is using pills"*
> …….
> (**Source: Male respondent, 42 years**)

This implies not all women agree using pills as a method family planning. This is because of the side-effects that comes with it. Both the husband and wife should come into agreement on either to use the pills or not.

Another informant responded that:

> *"I come from Koibarak and I talked with my wife and we are using family planning and she is using pills and at times she forgets to take them as she got pregnant. The hospital is far also and you might not get those pills in the hospital"*
> …….
> (**Source: Male respondent, 35 years**)

This implies that both wife and husband have the responsibility in making the all process of family planning. Women sometimes find it hard to do the process alone.

Another respondent reported that:

> *"It is there for instance my wife is using the 3year implant and it is good"*
> …….
> (**Source: Male respondent, 37 years**)

This means that not every method is long term and also effective for family planning. Both husband and wife should seat down and agree on method to use.

4.6 Communication on the use of Family Planning from Both Interviews and FGDs

The second objective of the study was to identify ways through which men and women communicate on the use of family planning in in Koibarak, Elgeyo Marakwet County. Communication among couples is very vital particularly in relation to the adoption of various family planning methods. Poor communication in relation to family planning methods may contribute to fights, separation and even divorce. For instance, if a husband finds out that his wife is not conceiving due to adoption of certain family planning method may bring a lot of troubles particularly if the husband was not consulted.

When participants were asked to state whether they communicate with their partners concerning family planning methods, they unanimously agreed.

One of them said;

> "*Yes, I do consult and talk with my husband because these children are not mine a lone. They are ours. Anything that involves them involve us.*"
> …….
> (**Source: Female respondent, 34 years**)

This statement implies that children belong to the family and therefore decision to plan on healthy family involves both couples.

In relation to communication on family planning issues, some women fear talking to their husbands due to the fact that the husband is the head of the family and a woman should not initiate any idea. Most of the women who participated in the study reported that it was their male couples who initiated family planning ideas. This therefore indicates that the idea of gender inequality in terms of family planning decisions still exists.

Conversely, male counterparts said that family planning options are more for female than they are for male and therefore it is prudent if women chose from the options.

One of the respondents reported that:

> *"Another thing is that this family planning will support our women either financially or any other kind of approval because we have to agree first at home as couples. We discuss on the number of children we want to have"*
> …….
> (**Source: Male respondent, 44 years**)

This means that communication among the couple and decision to use family planning is very important. It enables the couple to decide and reach into agreement on the number of children they would like to have and time to have. This reduces conflicts among in family and improves family livelihood of most families

Another respondent said that:

> *"It is the women who takes that responsibility and she is the one to inform her husband what is needed. Here in Marakwet the women are the one responsible for the house affairs but the husband takes other responsibility "*
> …….
> (**Source: Male respondent, 40 years**)

This means that, women should be in the forefront in informing their husbands on issues to do with family planning. In addition, men also should be ready and willing to offer the necessary support.

One of the informants reported that:

> *"The women are the one responsible and are the ones to talk to their husbands"*
> …….
> (**Source: Male respondent, 40 years, clinical officer**)

This implies that when it comes to family planning, women are the ones who are more informed than how their husbands are. They are the one who knows how it works and the effects that comes with them.

One of the respondents reported that:

> *"…as men we do not go to the clinic, we always think it is just for women. It is hard to find a man accompanying his wife to the clinic"*
> …….
> (**Source: Male respondent, 35 years**)

This implies that men always don't have full courage and confidence to accompany their spouses to clinic for family planning guidance. This has always affected the effectiveness of the all process.

On asking one of the respondents if he has ever accompanied his wife to clinic, this was the response:

> *"Not yet but we are trying to find a date so that we can go together"*
> …….
> (**Source: Female respondent, 35 years**)

This means that, too many families, going for a family planning is never a priority to them. It is a clear indication that less people have a full access to and knowledge to family planning benefits.

One of the respondents noted that

> "*Here in Koibarak for instance me, I sat and talked with my wife and she started using depo, then she developed high blood pressure and we thought it was the family planning so we opted to change and she wanted us to use condoms so I told her to change and use implant. Now she is fine pressure has reduced and she is now normal. I would also like to advice other to follow what we are doing*."
> ……
>
> (**Source: Male respondent, 41 years**)

This gave an implication that some couples communicate on the use of family planning which has led to the use of best family planning. And also, not all family planning methods works best for all.

4.7 Challenges Facing the Use of Family planning Methods

The third objective of the study was to establish the challenges faced in relation to usage of family planning methods between men and women in Koibarak, Elgeyo Marakwet County. Family planning has been faced with various hurdles within households.

Table 4.8: Challenges Facing the Use of Family planning Methods

	Challenges faced									
	Refusal	**Fear**	**Accessibility**	**Cultural**	**Religious**	**Lack of knowledge**	**Total**	**X^2**	**df**	**P**
Gender										
Male	2(8.3%)	0(0.0%)	2(8.3%)	0(0.0%)	2(8.3%)	0(0.0%)	6(25.0%)	8.000[a]	5	0.156
Female	2(8.3%)	5(20.8%)	2(8.3%)	4(16.7%)	2(8.3%)	3(12.5%)	18(75.0%)			
Age Bracket										
21-30 years	1(4.2%)	1(4.2%)	3(12.5%)	0(0.0%)	2(8.3%)	0(0.0%)	7(29.2%)	9.275[a]	10	0.506
31-40 years	2(8.3%)	2(8.3%)	1(4.2%)	2(8.3%)	1(4.2%)	1(4.2%)	9(37.5%)			
Above 40 years	1(4.2%)	2(8.3%)	0(0.0%)	2(8.3%)	1(4.2%)	2(8.3%)	8(33.3%)			
Education level										
No formal education	2(8.3%)	1(4.2%)	0(0.0%)	1(4.2%)	3(12.5%)	0(0.0%)	7(29.2%)	10.512[a]	15	0.786
Primary education	1(4.2%)	1(4.2%)	1(4.2%)	1(4.2%)	0(0.0%)	1(4.2%)	5(20.8%)			
Secondary education	1(4.2%)	2(8.3%)	1(4.2%)	1(4.2%)	0(0.0%)	1(4.2%)	6(25.0%)			
College education	0(0.0%)	1(4.2%)	2(8.3%)	1(4.2%)	1(4.2%)	1(4.2%)	6(25.0%)			
Children Number										
1 child	1(4.2%)	0(0.0%)	1(4.2%)	0(0.0%)	0(0.0%)	1(4.2%)	3(12.5%)	8.122[a]	15	0.919
2-3 children	1(4.2%)	1(4.2%)	1(4.2%)	1(4.2%)	2(8.3%)	1(4.2%)	7(29.2%)			
4-5 children	1(4.2%)	3(12.5%)	1(4.2%)	2(8.3%)	2(8.3%)	0(0.0%)	9(37.5%)			
6-7 children	1(4.2%)	1(4.2%)	1(4.2%)	1(4.2%)	0(0.0%)	1(4.2%)	5(20.8%)			

The study findings in Table 4.8 revealed that there was no significant association between gender, age bracket, education level, children number and family planning methods ($p>0.05$).

When asked to state various challenges that they face, the following findings were obtained from both interviews and Focused Group Discussions.

a. Spouse Refusal

Participants said that family planning is not a one-person decision especially for those who were married. When one partner refuses to consent of the adoption of family planning methods, then one has no choice than to shun the whole process. It was established that male partners hinder adoption of family planning with households.

b. Fear of Side Effects

It was also established family planning adoption is being hindered by people fearing the side effects that normally accompany such methods. It has been a common perception that various family planning methods have adverse side effects which has caused fear in some people. However, visiting a health officer helps in clarifying such perception.

One of respondent said that:

> "*The use of family planning has side effects for example the use of depot types affected my wife. After using depot, she started developing family planning which let us to change to use of condom*."
> …….
> (**Source: Female respondent, 38 years**)

This implies that the use of family planning can lead to someone developing other health problems like blood pressure. This has led to some people leaving its use.

c. Accessibility of FP methods

The study was conducted in remote areas where access to health facilities was problematic. As a matter of fact, the study found that one major challenge in the adoption and use of family planning methods is inaccessibility. Pills, condoms among others are some of the methods which need to be used frequently and therefore lack of their access may hinder family planning among couples.

One of the respondents noted that

> "*I come from Koibarak and I talked with my wife and we are using family planning and she is using pills and at times she forgets to take them as she got pregnant. Despite using the family planning its accessibility at times is a challenge. This is because the hospital is far and someone might not get those pills in the hospital*."
> ……
> (**Source: Male respondent, 35 years)**

This implies that, despite the effective communication between the couple on use of family planning intervention, the biggest challenge still comes on the availability of the family planning method.

d. Cultural Hindrance

Looking at the community where data was collected, children are seen as a blessing and a source of wealth. Furthermore, children ensured continuity. For one to be recognised and respected there is need to have a sizeable number of children. Thus, family planning may therefore be rejected based on cultural aspects.

One of the respondents noted that:

> "*In this area there are those who still follow their tradition whereby they do not take family planning seriously they claim that they have their own traditional ways but those in towns and the educated ones take family planning seriously this is because it enables them to organize their families and plan for the children, they are able to educate. This family planning is for the new generation who have been educated. Most people have accepted family planning even though it is done secretly*."
>
> ……
>
> (**Source: Male respondent, 55 years)**

This implies that the old still beliefs on the own culture and discourages the use of family planning which has acted to be the main hindrance to the use of family planning.

e. Religious Hindrance

It was established that some participants who are Christians are barred from using any family planning methods as it contradicts God's plan for people. For instance, Catholicism, have restrictions on contraception based on the belief that it is God's will to bring children into the world. Thus, religious believers who are Catholics for instance, might choose to avoid certain methods of family planning, such as birth control pill, in an effort to live their lives according to the teachings of their religion.

f. Lack of Knowledge on FP

Lack of pertinent information on the various family planning methods also restricts people from using them. People may fear not to adopt a particular method due to inadequate information that they may have. Thus, fear of the unknown creates anxiety.

One of the respondents revealed that:

> "*Currently majority of us do not have knowledge of new family planning of the best because in the past the government would announce even in the baraza about family planning. But nowadays it is not there unless you go to the health facility that is where you can be informed. Those who have not gone to school will not know because we do not have them in barazas anymore*."
> …….
> (**Source, couple respondent, 50 years**)

This implies that few individuals have full knowledge on family planning method and importance of their use. The main contributing factors being low level and intensity of campaigns and awareness done on family planning use.

Gender Based Perceptions

Gender perceptions were also found to be a critical challenge. This involved men and women having certain perceived risks as a result of the use of family planning methods. The two genders feared that their spouses may have negative thoughts on the request to use family planning methods such as suspicion of having infection, not trusting the husband and the like.

One of the respondents reported that:

> *"In this area in Marakwet there are those who still follow their tradition whereby they do not take family planning seriously they claim that they have their own traditional ways"*
> ……
> (**Source: Female respondent, 35 years)**

This implies that most families from a rural setting are less educated on modern ways of family planning. And therefore, this has interfered with the process of family planning.

One of the informants who was a doctor said that:

> "*You can find that a mother brings her child to us the doctors and they tell you that the child is going to form one or college please something, so you start wondering and you ask yourself why you want to expose this child to this thing. We tell them that you are safe from getting pregnant but not from contracting other diseases, so it is better for the child to get pregnant than to contract other diseases… The parents have misused the use of family planning and those contraceptives."*
> **……..**
> **(Source, Male respondent, 35 years, Doctor)**

This implies that parents especially mothers have missed the mark by exposing their daughters too early to contraceptives. School going girls therefore report to school with mentality that they are safe from pregnancy.

Another respondent reported that:

> *"It is not good, people like having less children and also, they believe in leadership according to the larger the number of the family... Yes, in terms of children"*
> **…….**
> **(Source: Male respondent, 60 years)**

This implies that in tradition beliefs of Marakwet, people belief that using family planning methods will deprive one of the community leadership and superiority.

Another respondent said:

> *"I come from Koibarak and I talked with my wife and we are using family planning and she is using pills and at times she forgets to take them as she got pregnant"*
> …….
> **(Source: Male respondent, 45 years)**

This implies that when the couples are not accountable enough to each other on use of the family planning, it might not be effective hence resulting to unplanned pregnancies.

KII, Village Elder reported that:

> *"We men have been excluded either deliberately or by default we have not been taught about family planning so I can say that we are totally excluded."*
> …….
> **(Source: Male respondent, 39 years)**

This means that men feel that family planning process is not their responsibility and the society has ruled them out of participating in the process.

Another informant responded that:

> *"The hospital is far also and you might not get those pills in the hospital"*
> …….
> **(Source: Female respondent, 40 years)**

This implies that long distance to hospital discourages most families from using the family planning methods. To them it seems like wasting of time and they find it better to continue with their normal live.

One of the respondents responded:

> *"You know what my child, this thing is for the whites and other people think that family planning is for the white people and also it is for the young generation who do not want many children I do not know if it is because they do not want to fill the world or is it because they cannot feed them but we want them to bear many children and this is a new thing brought in by other people"*
> …….
> (**Source: Male respondent, 60 years**)

This means that most old people don't appreciate the use of family planning. To them it is against their belief to use family planning as it limits the bearing of many children which is compulsory to them.

Another responded that:

> *"They perceive that those women using family planning have other relationship outside marriage so it encourages unfaithfulness in families"*
> …….
> (**Source: Female respondent, 35 years**)

This means that not all communities take the positive side of use of the family planning. To them it means like the women using the family planning tend to hide their unfaithfulness.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

The study aimed at investigating gender perceptions on the use of family planning methods among married men and women in Koibarak Location of Elgeyo Marakwet County. This chapter discusses the study findings in relation to study objectives.

5.2 Gender Based Perception on Family Planning Methods

The study's first objective was to examine the level of family planning methods between men and women of the Marakwet community in Koibarak, Elgeyo Marakwet County. The study findings established that both genders were aware of the various family planning methods. Both acknowledged the use of modern contraceptives, which include the use of pills, injections, in-plants, condoms, and coil, while the men reported that they preferred the traditional methods of birth control. Those that supported the use of traditional birth controls said that modern family planning methods have many negative than positive effects, and thus men fear the side effects of modern methods of FP. From these findings, it is evident that family planning methods are perceived as a female affair by men in Koibarak Location. Thus, this may justify why the majority of women are the ones using them. This could also be attributed to the societal socialization of the two genders on family planning usage and decisions where its use is emphasised by men. This concurs with Longbottom (2016), who found that family planning methods suffer from various setbacks due to misinformation regarding family planning's side effects.

This study found that the use of family planning comes with many side effects, as shown by the inclination of responses by the men and women, which has discouraged

most of the women from using some of the family planning procedures and the FP at large. This agrees with the study findings from a study done by, Alvergne, Stevens, and Gurmu (2017), who found out that fear of side-effects is also a commonly cited reason for contraceptive discontinuation by the men. Many studies have found that while some of these are based on actual health-related side-effects, many fears are based on rumours rather than personal experience. Further, the study found out that not all couples accept to use Depo for family planning. It shows that husbands should be the frontline in their families in the implementation of family planning. The same has resulted in families living in good standards, reducing the rate of children not attending school. This disagrees with the study done by Newmann, Zakaras, Tao, Onono, Bukusi, Cohen & Grossman (2016), who found out that key barriers to the use of family planning included: concerns about side effects of contraceptives; lack of knowledge about contraceptive methods; myths and misconceptions including fear of infertility and a lack of male focus in family planning methods and service delivery.

The study also found out that not all women agree with using pills as a method of family planning. This is because of the side-effects that come with it. Both the husband and wife should agree on either to use the pills or not. This agrees with Bhusal and Bhattarai (2018) study, which identified evidence of fear of FP side effects among females and males from India, Nepal, and Nigeria. Furthermore, fear of side-effects from hormonal methods among male partners has also been found to impact females' FP decision-making and their fear to use FP. Further, the study found out that both wife and husband are responsible for making all family planning processes. Women sometimes find it hard to do the process alone. This study disagrees with the study done by Adhikari (2019), who found out that women seemed to have a greater exposure since they regularly come into contact with lady health

workers and lady doctors, but that information is not passed on to their husbands or discussed openly. Also, men thought of vasectomy as against men's pride, and both males and females viewed the removal of the uterus as a permanent method.

Lastly, the study revealed that not every method is long term and also effective for family planning. Both husband and wife should sit down and agree on the method to use. This study agrees with Balogun et al. (2014) that the implant is so effective because there's no chance of making a mistake. Since it's in your arm, you can't forget to take it or use it incorrectly. It protects you from pregnancy all day, every day for up to 5 years. If you decide you want to get pregnant, a nurse or doctor can take it out, and you can get pregnant right away.

5.3 Gender based perspective on use of family planning from both Interviews and FGDS

The second objective of the study was to identify ways men and women perceive on the use of family planning in Koibarak, Elgeyo Marakwet County. Despite participants acknowledging that they do have a perspective on matters family planning, most of them, especially women, had joint decision-making reservations. This is particularly a cultural influence where men are the final decision-makers. Furthermore, any woman suggesting family planning usage may generate negative thoughts by her husband towards the wife, such as the cheating on him. Thus, in most cases, women adopt their husbands' decision regarding family planning. Similarly, Machiyama et al., (2017) in their study on husband-wife perception of family planning found that most Kenyan communities are patriarchal. Therefore, male have a different perspective on family planning as majority of them make decisions regarding family planning without involving their wives.

The study found out that children belong to the family and therefore, the decision to plan on healthy family involves both couples. This study disagrees with the study done by Dougherty et al., (2018) who mentioned, many families planning programs have focused mainly on women. Even though men are increasingly being "involved" by reproductive health programmes, men's view still seems to be peripheral and problematic. Also, communication among the couple and the decision to use family planning is very important. It enables the couple to decide and reach into an agreement on the number of children they would like to have and time to have. This reduces conflicts among in family and improves the family livelihood of most families. This study agrees with Harrington, McCoy, Drake, Matemo, John-Stewart, Kinuthia & Unger (2019), who studied husband-wife communication related to family planning use of contraceptives in Kenya. The authors reported that "the wife's perception of her husband's approval of family planning" has a significant impact on the current contraceptive use.

The study further found out that women should be at the forefront in informing their husbands on issues to do with family planning. In addition, men also should be ready and willing to offer the necessary support. This study agrees with Huda, Robertson, Chowdhuri, Sarker, Reichenbach and Somrongthong (2017) In Bangladesh, who said men often give their wives permission to practice contraception noncommittal way, without actually making a decision themselves; if anything goes wrong, they can blame their wives. Men have authority, but often they are reluctant to take responsibility. Also, from the study findings, when it comes to family planning, women are the ones who are more informed than how their husbands are. They are the one who knows how it works and the effects that comes with them. This study finding disagrees with Kriel et al., (2019) who found out that men facilitated contraceptive

use for their partners. The intervention's content and its training in communication skills are essential mechanisms for successfully enabling men to help couples use a contraceptive.

The study also found out that, men always don't have full courage and confidence to accompany their spouses to the clinic for family planning guidance. This has always affected the effectiveness of the all process. This study finding agrees with Adelekan, Omoregie and Edoni, (2014) who identified barriers to male involvement, including the perception that FP is women's activity and was not their custom to participate in the FP programme. More than half of the FGD discussants were of the view that men should provide their wives with transport fare and other resources they may need for FP. The majority of the respondents had never been involved in family planning with their wives.

From the study findings, too many families, going for family planning is never a priority. It is a clear indication that fewer people have full access to and knowledge to family planning benefits. This study disagrees with the study done by Carter and Renshaw (2016), who investigated the determinants of spousal communication and found out they are varied and complex. In Sub-Saharan Africa, gender roles and norms are particularly salient, shaping spousal communication and subsequent FP decision-making in significant ways. Although contraceptive methods and services are frequently geared toward women, men are often the primary decision-makers on family size and their partner's use of FP methods. However, there are respondents who noted that they are communicating as couples on the use of family planning.

Lastly, the study found out that, some couples communicate on the use of family planning which has led to the use of best family planning. And also, not all family

planning methods works best for all. This agrees with the study done by Rogers *et al*. (2019), who found out that many family planning programs have focused mainly on women. Even though men are increasingly being "involved" by reproductive health programmes, men's view still seems to be that they are peripheral and problematic.

5.4 Establish the gendered perceived challenges on use of family planning methods

The third objective of the study was to establish the gendered perceived challenges faced in relation to the usage of family planning methods between men and women in Koibarak, Elgeyo Marakwet County. Some of the study's challenges include spouse refusing to cooperate; fear of side effects; low accessibility of FP methods; cultural hindrance; religious hindrance, and lack of family planning knowledge. All these in one way or another may have made men and women in the study are not to use family planning methods. This finding correlates with a study by CColfer et al. (2015) on the barriers (including fear of the side effects) as contributing to low adoption of family planning.

The study found out that few individuals have full knowledge of family planning methods and their importance. The main contributing factors to low knowledge of family planning are low level and intensity of campaigns and awareness of family planning use. This disagrees with the study done by Tilahun, Coene, Luchters, Kassahun, Leye, Temmerman and Degomme, (2015) who found out that the involved couples well knew the concept of family planning. The sex-stratified analysis showed pills and injectables were commonly known by both sexes, while long-term contraceptive methods were better known by women, and traditional methods as well

as emergency contraception by men. Formal education was the most important factor associated with better knowledge about contraceptive methods.

In addition, from the findings, despite the effective communication between the couple on the use of family planning intervention, the biggest challenge still comes on the availability of the family planning method especially to women. This agrees with the study done by Casterline, Sathar, and Haque (2001) whom in their study of Punjab articulated six categories of barriers to family planning: the strength of motivation to avoid pregnancy, knowledge of contraception, costs of practising contraception (including perceptions of social, cultural, and religious costs), husband's opposition to family planning, health concerns about contraception, and inadequate access to family planning methods. The study further found that the old women still beliefs on the own culture and discourage the use of family planning which has acted to be the main hindrance to family planning. This agrees with the study done by Amin, (2014) who outlined the barriers to family planning use: ambivalent fertility preferences, perceived infecundity and lack of knowledge of family planning, social and cultural unacceptability of family planning, fear of health effects, inadequate services, and opposition from husband, relatives, and community members.

Further from the study findings, most families from a rural setting are less educated on modern ways of family planning. And therefore, this has interfered with the process of family planning for both genders. This agrees with the study by Kabagenyi, Reid, Ntozi and Atuyambe, (2016) who found out that sociocultural expectations and values attached to marriage, women and childbearing remain an impediment using family planning methods. They also suggest a need to eradicate the cultural beliefs

and practices that hinder people from using contraceptives, as well as a need to scale-up family planning services and sensitization at the grassroots.

The study findings also indicated that parents had did wrong by exposing their daughters too early to contraceptives. School going girls, therefore, report to school with the mentality that they are safe from pregnancy. This study agrees with Machira and Palamuleni, (2017) who argue that the teen mothers are still at risk of having a repeat teenage pregnancy due to their non-use of contraceptives. This implies that less than 50% of teen mother's use contraceptives after experiencing teen birth. It is noted that health care factors such as the use of antenatal care, awareness of pregnancy complications, attainment of primary education and exposure to media predict teen mothers' use of modern contraceptives. Further, findings show that Marakwet, people believe that using family planning methods will deprive one of the community leadership and superiority. This study finding agrees with Wulifan, Brenner, Jahn and De Allegri (2015) who articulated six categories of barriers to family planning: the strength of motivation to avoid pregnancy, knowledge of contraception, costs of practising contraception (including perceptions of social, cultural, and religious costs), husband's opposition to family planning, health concerns about contraception, and inadequate access.

The study findings show that when the couples are not accountable enough to each other on family planning, it might not be effective, resulting in unplanned pregnancies. This study finding agrees with Pace *et al.,* (2016) who noted that non-daily administration was one of the main reason's women forget to use the pill. Daily use and 'will forget to take it' were the primary reasons for not selecting the pill, while

the main reasons for not choosing the patch included 'not discrete, visible' and 'can fall off'.

From the study findings, the family planning process is not their responsibility, and society has ruled them out of participating in the process. The tradition takes the same as an issue for women. This study disagrees with Kabagenyi et al., (2016) who found out that men significantly impact the current contraceptive use. The study suggested that men's opinion and perception regarding reproduction have a strong impact on women's perception and subsequent behaviour.

In addition, the study findings show that long-distance to hospital discourages most families from using the family planning methods. To them, it seems like wasting time, and they find it better to continue with their normal life. This study finding agrees with Ouma et al., (2015) who found significant obstacles to family planning usage included; long distance to Health facility, unavailability of preferred contraceptive methods, absenteeism of family planning providers, high cost of managing side effects, desire for big family size, children dying less than five years old, husbands forbidding women from using family planning and lack of community leaders' involvement in the family planning programme. In addition, most older people don't appreciate the use of family planning. It is against their belief to use family planning as it limits the bearing of many children that is compulsory to them. This study agrees with Dansereau et al., (2015) who found out that there were intergenerational and cultural gaps in the acceptability of family planning, and in some community's family planning use was greatly limited by gender roles and religious objections to contraception. Men strongly influenced family planning choices in many households but were largely unreached by outreach and education programs due to their work

hours. Respondents were aware of many modern methods but often lacked deeper knowledge and held misconceptions about some hormonal methods' long-term fertility risks.

Lastly, the study findings revealed that not all communities take the positive side of family planning. To them, it means like the women using family planning tend to hide their unfaithfulness. This agrees with Kabagenyi et al., (2014) who brings out the concerns that women's use of contraceptives will lead to extramarital sexual relations. In general, knowledge of effective contraceptive methods was high. However, lack of time and overall limited awareness regarding the specific role of men in reproductive health was also thought to deter men's meaningful involvement in issues related to fertility regulation.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The purpose of the study was to investigate gender perceptions on the use of family planning methods among married men and women in Koibarak Location of Elgeyo Marakwet County.

Regarding the level of usage of family planning methods, it can be concluded that despite the enhanced awareness of most couples to modern family planning methods, still a number of them have not adopted these methods due to various factors such as perceived side effects associated with each of the methods and other societal cultural factors. This has been amplified by lack of adequate information and knowledge on family planning methods. However, for those couples who had adopted family planning methods, pills were commonly used. Furthermore, women have been found to be the ones using the methods than the men.

Similarly, some participants still prefer the tradition birth control system such prolonged breast feeding as the best. This also centres around inadequate information as well as beliefs that modern family planning methods are dangerous and health risk. This is a misconception that should be discouraged through awareness creation. This implies that the community members should be well screened to know which methods is suitable.

Regarding communication on the use of family planning, results indicate that communication regarding family planning within households in the study area is only one way; from the husbands to their wives. For effective communication on the usage of family planning, there is need to promote community sensitization on the

importance of joint decision making on matters related to family planning so as to improve on the usage of family planning methods in the study area.

It was also established that adoption of family planning methods is faced with challenges. For instance, lack of right information on existing methods, traditional and cultural practices, poverty, lack of modern family planning education, perceived risks, ignorance, distance from family planning methods, as well as religious practices still hinder some section of the community from accessing modern family planning methods were notable challenges that the study identified.

6.2 Recommendations

It was established from the study findings that despite the majority adopting new family planning methods, they still use traditional methods of family planning. These methods might not be as effective as modern ones. There is, therefore, a need for the county government of Elgeyo Marakwet, through its ministry of health, to intensify gendered campaigns and sensitizations on the importance and benefits of adopting modern family planning methods.

Findings also revealed that in most cases, husbands (men) were in charge of decision-making regarding the adoption of family planning methods. Therefore, there is a need for all the stakeholders in health both at the county and national levels to encourage constructive partner communication and engagements through campaigns to promote gender equity and equality in the adoption of family planning decision-making.

From the findings, it was established that the adoption of modern family planning is faced with numerous challenges, including the fear of the side effects, cultural and religious restrictions. There is, therefore, need to intensify on the gendered awareness

creation through seminars, barazas and health forums in order to increase awareness and knowledge-ability on the use of modern family planning. The government and non-governmental agencies should provide community sensitization programmes aimed at improving male involvement in FP.

6.2.1 Recommendation for Further Research

The study recommends the following areas for further research:

1. Enhancing gendered education and sensitizations on the modern family planning methods in order to increase their uptake among married couples.
2. The role health care stakeholders in improving gendered perception on the usage and adoption of family planning methods among married couples.
3. Overcoming cultural and religious gendered impediments to modern family planning methods.

REFERENCES

Adams, J. E., & Mikesell, M. (2017). And Damned If They Don't: Prototype Theories to End Punitive Policies against Pregnant People Living in Poverty. *Geo. J. Gender & L.*, *18*, 283.

Adelekan, A., Omoregie, P., & Edoni, E. (2014). Male involvement in family planning: challenges and way forward. *International Journal of Population Research*, *2014*.

Adelekan, A., Omoregie, P., & Edoni, E. (2019). Male involvement in family planning: challenges and way forward. *International Journal of Population Research*, *2014*.

Adhikari, R. (2019). US "global gag rule" on abortion is limiting family planning choices for women in Nepal. *BMJ*, *366*, l5354.

Alderson, P., & Morrow, V. (2020). *The ethics of research with children and young people: A practical handbook*. SAGE Publications Limited.

Alege, S. G., Matovu, J. K., Ssensalire, S., & Nabiwemba, E. (2016). Knowledge, sources and use of family planning methods among women aged 15-49 years in Uganda: a cross-sectional study. *Pan African Medical Journal*, *24*(1).

Alvergne, A., Stevens, R., & Gurmu, E. (2017). Side effects and the need for secrecy: characterising discontinuation of modern contraception and its causes in Ethiopia using mixed methods. *Contraception and reproductive medicine*, *2*(1), 24.

Amin, T. (2014). Trend and Pattern of Use and Barriers to Family Planning in Egypt. In *International Public Health Forum* (Vol. 1, No. 4).

Arousell, J., & Carlbom, A. (2016). Culture and religious beliefs in relation to reproductive health. *Best practice & research Clinical obstetrics & gynaecology*, *32*, 77-87.

Austin, A. (2015). Unmet contraceptive needs among married Nigerian women: an examination of trends and drivers. *Contraception*, *91*(1), 31-38.

Basten, S., & Jiang, Q. (2015). Fertility in China: An uncertain future. *Population Studies*, *69*(sup1), S97-S105.

Becker, M. H. (1990). Theoretical models of adherence and strategies for improving adherence. In E. B. S. S. A. Schumaker, and J. K. Ockene (Eds.) (Ed.), *The handbook of health behaviour change* (pp. 5-43). New York Springer.

Becker, M. H., Drachman, R. H., andKirscht, J. P. (1974). A new approach to explaining sick-role behavior in low-income populations. *American Journal of Public Health*, 64(3), 205-216.

Bhusal, C. K., & Bhattarai, S. (2018). Factors affecting unmet need of family planning among married Tharu women of Dang District, Nepal. *International journal of reproductive medicine*, *2018*.

Bloom, D. E., Canning, D., & Lubet, A. (2015). Global population aging: Facts, challenges, solutions & perspectives. *Daedalus*, *144*(2), 80-92.

Blue, S., Shove, E., Carmona, C., & Kelly, M. P. (2016). Theories of practice and public health: understanding (un) healthy practices. *Critical Public Health*, *26*(1), 36-50.

Boddy, C. R. (2016). Sample size for qualitative research. *Qualitative Market Research: An International Journal*.

Bongaarts, J. (2009). Human population growth and the demographic transition. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *364*(1532), 2985-2990.

Brooks, H. M. (2017). Anti-malarial strategies among vulnerable populations: exploring bed net underutilization among internally displaced persons and novel adjunctive therapies for cerebral malaria.

Bryman, A. (2016). *Social research methods*. Oxford university press.

Bujang, M. A., Omar, E. D., & Baharum, N. A. (2018). A review on sample size determination for Cronbach's alpha test: a simple guide for researchers. *The Malaysian journal of medical sciences: MJMS*, *25*(6), 85.

Bulatao, R. A. (Ed.). (2019). *Choosing a contraceptive: method choice in Asia and the United States*. Routledge.

Butto, D., & Mburu, S. (2015). Factors associated with male involvement in family planning in West Pokot County, Kenya.

Carter, S. P., & Renshaw, K. D. (2016). Spousal communication during military deployments: A review. *Journal of Family Issues*, *37*(16), 2309-2332.

Catalano, P. M., & Shankar, K. (2017). Obesity and pregnancy: mechanisms of short term and long-term adverse consequences for mother and child. *Bmj*, *356*, j1.

Chakraborty, N. M., Mbondo, M., & Wanderi, J. (2016). Evaluating the impact of social franchising on family planning use in Kenya. *Journal of Health, Population and Nutrition*, *35*(1), 19.

Chant, S. (2017). Single-Pa rent Fa mi lies: Choice or Constraint? The Formation of Female-Headed Households in Mexican Shanty Towns. *Development: Critical Essays in Human Geography*, 61.

Cleland, J., & Machiyama, K. (2015, January). Unmet need for family planning: past achievements and remaining challenges. In *Seminars in reproductive medicine* (Vol. 33, No. 01, pp. 011-016). Thieme Medical Publishers.

Coale, A. J., & Hoover, E. M. (2015). *Population growth and economic development*. Princeton University Press.

Colfer, C. J. P., Achdiawan, R., Roshetko, J. M., Mulyoutami, E., Yuliani, E. L., Mulyana, A., ... & Adnan, H. (2015). The balance of power in household decision-making: encouraging news on gender in southern Sulawesi. *World development*, *76*, 147-164.

Dalaba, M. A., Stone, A. E., Krumholz, A. R., Oduro, A. R., Phillips, J. F., & Adongo, P. B. (2016). A qualitative analysis of the effect of a community-based primary health care programme on reproductive preferences and contraceptive use among the Kassena-Nankana of northern Ghana. *BMC Health Services Research*, *16*(1), 80.

Dereuddre, R., Van de Putte, B., & Bracke, P. (2016). Ready, willing, and able: Contraceptive use patterns across Europe. *European Journal of Population*, *32*(4), 543-573.

Diamond-Smith, N., Campbell, M., & Madan, S. (2012). Misinformation and fear of side-effects of family planning. *Culture, health & sexuality*, *14*(4), 421-433.

Diamond-Smith, N., Campbell, M., & Madan, S. (2012). Misinformation and fear of side-effects of family planning. *Culture, health & sexuality*, *14*(4), 421-433.

Digitale, J., Psaki, S., Soler-Hampejsek, E., & Mensch, B. S. (2017). Correlates of contraceptive use and health facility choice among young women in Malawi. *The Annals of the American Academy of Political and Social Science*, *669*(1), 93-124.

Dougherty, A., Kayongo, A., Deans, S., Mundaka, J., Nassali, F., Sewanyana, J., ... & Heil, S. H. (2018). Knowledge and use of family planning among men in rural Uganda. *BMC public health*, *18*(1), 1294.

Farrell, K. (2017). The rapid urban growth triad: a new conceptual framework for examining the urban transition in developing countries. *Sustainability*, *9*(8), 1407.

Fotrousi, F., Seyff, N., & Börstler, J. (2017, September). Ethical considerations in research on user feedback. In *2017 IEEE 25th International Requirements Engineering Conference Workshops (REW)* (pp. 194-198). IEEE.

Ganle, J. K., Obeng, B., Segbefia, A. Y., Mwinyuri, V., Yeboah, J. Y., & Baatiema, L. (2015). How intra-familial decision-making affects women's access to, and use of maternal healthcare services in Ghana: a qualitative study. *BMC pregnancy and childbirth*, *15*(1), 173.

Gawlik, K. (2018). Focus group interviews. In *Qualitative methodologies in organization studies* (pp. 97-126). Palgrave Macmillan, Cham.

Greene, R. L. (2000). *The MMPI-2: An interpretive manual*. Allyn & Bacon.

Guest, G., Namey, E., Taylor, J., Eley, N., & McKenna, K. (2017). Comparing focus groups and individual interviews: findings from a randomized study. *International Journal of Social Research Methodology*, *20*(6), 693-708.

Gueye, A., Speizer, I. S., Corroon, M., & Okigbo, C. C. (2015). Belief in family planning myths at the individual and community levels and modern contraceptive use in urban Africa. *International perspectives on sexual and reproductive health*, *41*(4), 191.

Gure, F., Dahir, M. K., Yusuf, M., & Foster, A. M. (2016). Emergency contraception in post-conflict Somalia: An assessment of awareness and perceptions of need. *Studies in family planning*, *47*(1), 69-81.

Harrington, E. K., McCoy, E. E., Drake, A. L., Matemo, D., John-Stewart, G., Kinuthia, J., & Unger, J. A. (2019). Engaging men in an mHealth approach to support postpartum family planning among couples in Kenya: a qualitative study. *Reproductive health*, *16*(1), 17.

Huda, F. A., Robertson, Y., Chowdhuri, S., Sarker, B. K., Reichenbach, L., & Somrongthong, R. (2017). Contraceptive practices among married women of reproductive age in Bangladesh: a review of the evidence. *Reproductive Health*, *14*(1), 69.

Jacobs, K., & Kes, A. (2015). The ambiguity of joint asset ownership: cautionary tales from Uganda and South Africa. *Feminist Economics*, *21*(3), 23-55.

Jwan, J. O., & Ong'ondo, C. O. (2011). Qualitative research: An introduction to principles and techniques. *Eldoret, Moi University*.

Kabagenyi, A., Reid, A., Ntozi, J., & Atuyambe, L. (2016). Socio-cultural inhibitors to use of modern contraceptive techniques in rural Uganda: a qualitative study. *The Pan African Medical Journal*, *25*.

Keller, H., & Trendelenburg, C. (Eds.). (2019). *Data Presentation/Interpretation* (Vol. 2). Walter de Gruyter GmbH & Co KG.

Kellstedt, P. M., & Whitten, G. D. (2018). *The fundamentals of political science research*. Cambridge University Press.

Kenya National Bureau of Statistics. (2019). 2019 Kenya Population and Housing Census Volume I: Population by County and Sub-County.

Keyonzo, N., Nyachae, P., Kagwe, P., Kilonzo, M., Mumba, F., Owino, K., ... & Simmons, R. (2015). From project to program: Tupange's experience with scaling up family planning interventions in urban Kenya. *Reproductive Health Matters*, *23*(45), 103-113.

Khan, S., & Zaheer, S. (2017). Socio-demographic and reproductive health profile of women who experienced signs of obstetric fistula: Results from Pakistan Demographic and Health Survey (PDHS) 2006–2007. *Midwifery*, *54*, 61-66.

Kim, J. (2016). Female education and its impact on fertility. *IZA World of Labor*.

Klaus, A. (2019). *Every Child a Lion: The Origins of Maternal and Infant Health Policy in the US and France*. Cornell University Press.

Kost, K., & Lindberg, L. (2015). Pregnancy intentions, maternal behaviors, and infant health: investigating relationships with new measures and propensity score analysis. *Demography*, *52*(1), 83-111.

Kriel, Y., Milford, C., Cordero, J., Suleman, F., Beksinska, M., Steyn, P., & Smit, J. A. (2019). Male partner influence on family planning and contraceptive use: perspectives from community members and healthcare providers in KwaZulu-Natal, South Africa. *Reproductive health*, *16*(1), 89.

Laird, J., Clarke, J., Brockmann, B., & Stein, L. A. R. (2020). Fatherhood, Reproductive Health, and Incarcerated Men: A Qualitative Study with Implications for Reentry. *Journal of Correctional Health Care*, *26*(3), 267-278.

Lince-Deroche, N., Pleaner, M., Morroni, C., Mullick, S., Firnhaber, C., Harries, J., ... & Holele, P. (2016). Achieving universal access to sexual and reproductive health services: the potential and pitfalls for contraceptive services in South Africa. *South African Health Review*, *2016*(1), 95-108.

Lincoln, J., Mohammadnezhad, M., & Khan, S. (2018). Knowledge, Attitudes, and Practices of Family Planning Among Women of Reproductive Age in Suva, Fiji in 2017. *J Women's Health Care*, *7*(3), 431.

Longbottom, D. (2016). The qualitative research process part 2: data analysis and data presentation. In *Alternative Market Research Methods* (pp. 54-66). Routledge.

Lusey, H., San Sebastian, M., Christianson, M., & Edin, K. E. (2018). Prevalence and correlates of gender inequitable norms among young, church-going women and men in Kinshasa, Democratic Republic of Congo. *BMC public health*, *18*(1), 887.

Machira, K., & Palamuleni, M. (2017). Factors influencing women's utilization of public health care services during childbirth in Malawi public health facility utilization. *African health sciences*, *17*(2), 400-408.

Machiyama, K., Casterline, J. B., Mumah, J. N., Huda, F. A., Obare, F., Odwe, G., ... & Cleland, J. (2017). Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: protocol for a multi-site cohort study. *Reproductive health*, *14*(1), 23.

Machiyama, K., Casterline, J. B., Mumah, J. N., Huda, F. A., Obare, F., Odwe, G., ... & Cleland, J. (2017). Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: protocol for a multi-site cohort study. *Reproductive health*, *14*(1), 23.

Mahapatro, M. (2016). Does women's empowerment increase accessibility to healthcare among women facing domestic violence? *Development in practice*, *26*(8), 1024-1036.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative health research*, *26*(13), 1753-1760.

Mandal, M., Muralidharan, A., & Pappa, S. (2017). A review of measures of women's empowerment and related gender constructs in family planning and maternal health program evaluations in low-and middle-income countries. *BMC pregnancy and childbirth*, *17*(2), 342.

Mansor, M. B., Abdullah, K. L., Akhtar, K., Jusoh, A. S., Ghazali, S. B., Haque, M., & Choon, L. C. (2015). The prevalence of family planning practice and associated factors among women in Serdang, Selangor. *Malaysian Journal of Public Health Medicine*, *15*(3), 147-156.

Mansour, A. M., Malkawi, A. O., Sato, T., Hamaideh, S. H., & Hanouneh, S. I. (2016). Men's perceptions of and participation in family planning in Aqaba and Ma'an governorates, Jordan. *EMHJ-Eastern Mediterranean Health Journal*, *22*(2), 124-132.

Mattebo, M., Sharma, B., Dahlkvist, E., Molinder, E., & Erlandsson, K. (2016). Perceptions of the role of the man in family planning, during pregnancy and childbirth: A qualitative study with fifteen Nepali men. *Journal of Asian Midwives*, *3*(1), 31-45.

Mboane, R., & Bhatta, M. P. (2015). Influence of a husband's healthcare decision making role on a woman's intention to use contraceptives among Mozambican women. *Reproductive health*, *12*(1), 36.

Mohamed, S. F., Izugbara, C., Moore, A. M., Mutua, M., Kimani-Murage, E. W., Ziraba, A. K., ... & Egesa, C. (2015). The estimated incidence of induced abortion in Kenya: a cross-sectional study. *BMC pregnancy and childbirth*, *15*(1), 185.

Molitoris, J. (2016). Feeling the Squeeze: The Effect of Birth Spacing on Infant and Child Mortality during the Demographic Transition. *Available at SSRN 2773587*.

Moronkola, O. A., Ojediran, M. M., & Amosu, A. (2016). Reproductive health knowledge, beliefs and determinants of contraceptives use among women attending family planning clinics in Ibadan, Nigeria. *African Health Sciences*, *6*(3), 155-159.

Msoka, A. C., Pallangyo, E. S., Brownie, S. M., & Holroyd, E. (2019). The male role as "King of the Family": barriers to Vasectomy uptake. *Africa Journal of Nursing and Midwifery*, *21*(2), 1-18.

Msoka, A. C., Pallangyo, E. S., Brownie, S., & Holroyd, E. (2019). My husband will love me more if I give birth to more children: Rural women's perceptions and beliefs on family planning services utilization in a low resource setting. *International Journal of Africa Nursing Sciences*, *10*, 152-158.

Najafi-Sharjabad, F., Rahman, H. A., Hanafiah, M., & Yahya, S. Z. S. (2014). Spousal communication on family planning and perceived social support for contraceptive practices in a sample of Malaysian women. *Iranian journal of nursing and midwifery research*, *19*(7 Suppl1), S19.

Nakao, Y. (2015). Aging and Social Problems in Tanzania, a Demographically Young Country in Africa.

Newmann, S. J., Zakaras, J. M., Tao, A. R., Onono, M., Bukusi, E. A., Cohen, C. R., ... & Grossman, D. (2016). Integrating family planning into HIV care in western Kenya: HIV care providers' perspectives and experiences one year following integration. *AIDS care*, *28*(2), 209-213.

Nsubuga, H., Sekandi, J. N., Sempeera, H., & Makumbi, F. E. (2015). Contraceptive use, knowledge, attitude, perceptions and sexual behavior among female University students in Uganda: a cross-sectional survey. *BMC women's health*, *16*(1), 6.

Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M., & Kays, M. (2015). Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. *BMC public health*, *15*(1), 1-9.

Okigbo, C. C., Speizer, I. S., Corroon, M., & Gueye, A. (2015). Exposure to family planning messages and modern contraceptive use among men in urban Kenya, Nigeria, and Senegal: a cross-sectional study. *Reproductive health*, *12*(1), 63.

Orach, C. G., Otim, G., Aporomon, J. F., Amone, R., Okello, S. A., Odongkara, B., & Komakech, H. (2015). Perceptions, attitude and use of family planning services in post conflict Gulu district, northern Uganda. *Conflict and health*, *9*(1), 24.

Ouma, P. O., Maina, J., Thuranira, P. N., Macharia, P. M., Alegana, V. A., English, M., ... & Snow, R. W. (2018). Access to emergency hospital care provided by the public sector in sub-Saharan Africa in 2015: a geocoded inventory and spatial analysis. *The Lancet Global Health*, *6*(3), e342-e350.

Ozaki, A., Guadalupe, A., Saquido, A. B., Gepte, D. F., Higuchi, A., Morita, T., & Tanimoto, T. (2017). Family planning as a possible measure to alleviate poverty in the Philippines–beyond sociocultural norms and pervasive opposition. *International journal of health policy and management*, *6*(11), 683.

Pace, L. E., Dusetzina, S. B., & Keating, N. L. (2016). Early impact of the Affordable Care Act on oral contraceptive cost sharing, discontinuation, and no adherence. *Health Affairs*, *35*(9), 1616-1624.

Pillai, V. K., & Wang, G. S. (2018). *Women's reproductive rights in developing countries*. Routledge.

Prata, N., Bell, S., Fraser, A., Carvalho, A., Neves, I., & Nieto-Andrade, B. (2017). Partner support for family planning and modern contraceptive use in Luanda, Angola. *African journal of reproductive health*, *21*(2), 35-48.

Queirós, A., Faria, D., & Almeida, F. (2017). Strengths and limitations of qualitative and quantitative research methods. *European Journal of Education Studies*.

Raj, A., Ghule, M., Ritter, J., Battala, M., Gajanan, V., Nair, S., ... & Saggurti, N. (2016). Cluster randomized controlled trial evaluation of a gender equity and family planning intervention for married men and couples in rural India. *PloS one*, *11*(5), e0153190.

RamaRao, S., & Jain, A. K. (2015). Aligning goals, intents, and performance indicators in family planning service delivery. *Studies in family planning*, *46*(1), 97-104.

Rashid, S., Sohail, S., & Munim, T. F. (2017). Family Planning Methods; Knowledge, Perceptions, And Ever Use of Modern Family Planning Methods Among Childbearing Women in Tertiary Care Hospital. *Professional Medical Journal*, *24*(8).

Rogers, C., Sapkota, S., Tako, A., & Dantas, J. A. (2019). Abortion in Nepal: perspectives of a cross-section of sexual and reproductive health and rights professionals. *BMC women's health*, *19*(1), 40.

Rosenstock, I. M. (1974). Historical origins of the health belief model. In M. H. Becker (Ed.), *The health belief model and personal health behaviour* (pp. 1-8). New Jersey: Charles B. Slack, INC

Rusibamayila, A., Phillips, J., Kalollela, A., Jackson, E., & Baynes, C. (2017). Factors influencing pregnancy intentions and contraceptive use: an exploration of the 'unmet need for family planning'in Tanzania. *Culture, health & sexuality*, *19*(1), 1-16.

Schwandt, H. M., Skinner, J., Hebert, L. E., & Saad, A. (2015). Perceived risks associated with contraceptive method use among men and women in Ibadan and Kaduna, Nigeria. *African Journal of Reproductive Health*, *19*(4), 31-40.

Short, S. E., & Kiros, G. E. (2002). Husbands, wives, sons, and daughters: Fertility preferences and the demand for contraception in Ethiopia. *Population Research and Policy Review*, *21*(5), 377-402.

Silwal, S., & Neupane, S. (2018). Knowledge and Attitude of Men on Contraception Methods. *Journal of Karnali Academy of Health Sciences*, *1*(3), 41-44.

Simon, J. L. (2019). *The economics of population growth*. Princeton university press.

Svallfors, S., & Billingsley, S. (2019). Conflict and contraception in Colombia. *Studies in family planning*, *50*(2), 87-112.

Tao, A. R., Onono, M., Baum, S., Grossman, D., Steinfeld, R., Cohen, C. R., ... & Newmann, S. J. (2015). Providers' perspectives on male involvement in family planning in the context of a cluster-randomized controlled trial evaluating integrating family planning into HIV care in Nyanza Province, Kenya. *AIDS care*, *27*(1), 31-37.

Tilahun, T., Coene, G., Temmerman, M., & Degomme, O. (2015). Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. *BMC Public Health*, *15*(1), 682.

Tilahun, T., Coene, G., Temmerman, M., & Degomme, O. (2015). Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. *BMC Public Health*, *15*(1), 682.

Tilly, L. A., & Scott, J. W. (2016). *Women, work and family*. Routledge.

Valekar, S. S., Pandve, H. T., Chawla, P., & Mane, A. (2017). Assessment of unmet needs of family planning and reasons for non-use of contraceptive methods among women in reproductive age in rural community. *J Community Med Health Educ*, *7*, 1-5.

Wambui, T., Ek, A. C., & Alehagen, S. (2019). Perceptions of family planning among low-income men in Western Kenya. *International nursing review*, *56*(3), 340-345.

Wasti, S. P., Simmons, R., Limbu, N., Chipanta, S., Haile, L., Velcoff, J., & Shattuck, D. (2017). Side-effects and social norms influencing family planning use in Nepal. *Kathmandu Univ. Med. J*, *15*, 222-9.

Wegs, C., Creanga, A. A., Galavotti, C., & Wamalwa, E. (2016). Community dialogue to shift social norms and enable family planning: an evaluation of the family planning results initiative in Kenya. *PloS one*, *11*(4), e0153907.

Wegs, C., Creanga, A. A., Galavotti, C., & Wamalwa, E. (2016). Community dialogue to shift social norms and enable family planning: an evaluation of the family planning results initiative in Kenya. *PloS one*, *11*(4), e0153907.

Withers, M., Dworkin, S. L., Onono, M., Oyier, B., Cohen, C. R., Bukusi, E. A., & Newmann, S. J. (2015). Men's perspectives on their role in family planning in Nyanza Province, Kenya. *Studies in family planning*, *46*(2), 201-215.

Withers, M., Dworkin, S. L., Zakaras, J. M., Onono, M., Oyier, B., Cohen, C. R., ... & Newmann, S. J. (2015). 'Women now wear trousers': men's perceptions of family planning in the context of changing gender relations in western Kenya. *Culture, health & sexuality*, *17*(9), 1132-1146.

World Health Organization. (2015). *Trends in maternal mortality: 1990-2015: estimates from WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. World Health Organization.

World Health Organization. (2018). *WHO meeting on ethical, legal, human rights and social accountability implications of self-care interventions for sexual and reproductive health, 12–14 March 2018, Brocher Foundation, Hermance, Switzerland: summary report* (No. WHO/FWC/18.30). World Health Organization.

World Population Prospects (2019). United Nations population estimates and projections. Accessed from: http://worldpopulationreview.com/countries/kenya-population, on 20th June 2019

Wrigley, E. A. (2016). *The path to sustained growth: England's transition from an organic economy to an industrial revolution*. Cambridge University Press.

Wulifan, J. K., Brenner, S., Jahn, A., & De Allegri, M. (2015). A scoping review on determinants of unmet need for family planning among women of reproductive age in low- and middle-income countries. *BMC women's health*, *16*(1), 2.

Yates, J., & Leggett, T. (2016). Qualitative research: An introduction. *Radiologic technology*, *88*(2), 225-231.

Yin, R. K. (2017). *Case study research and applications: Design and methods*. Sage publications.

Yin, R. K. (2018). Case study research and applications.

APPENDICES

Appendix I: Consent Form

Dear Participant,

My name is Anne Yano a Master's student at Moi University, College of Health Sciences, School of Public Health. I am conducting a study on 'gender-based perceptions on use of family planning among Marakwet community in Koibarak'. You have been selected to participate in my study by providing responses to the questions asked. Your responses will be kept confidential and will be combined with the responses of other participants during analysis. Your personal identity will not appear in any part of report. Your participation in this project is voluntary. You have a right to decline or withdraw and discontinue your participation at any time without penalty. If you feel uncomfortable at any stage of the interview, feel free to decline to answer any question or to end the interview. There are no apparent benefits for participating in the study.

Voluntary participation: I have read and understand the explanation provided for me. I have had all my questions answered to my satisfaction and I voluntarily agree to participate in this study. I have been a copy of this consent form

Participant signature_____ Date _____

Thank You

Ann Yano: 0721579908

Appendix II: Interview Schedule

This is an interviewer administered interview schedule. Its purpose is to solicit information about Gender based perception on family planning. Kindly answer the questions as honestly as possible.

Section A: Demographic data

1. Please state you gender
    a. Male [ ]
    b. Female [ ]
2. Your Age
    i. 20 years and below [ ]
    ii. 21-30 years [ ]
    iii. 31-40 years [ ]
    iv. Above 40 years [ ]
3. Your Education Level
    a. Primary [ ]
    b. Secondary [ ]
    c. College [ ]
    d. Any other (specify). …….
4. Number of children
    i. Only 1 [ ]
    ii. 2-3 [ ]
    iii. 4-5 [ ]
    iv. 6-7 [ ]
    v. Above 7 [ ]

Section B: interview guide.

1. In your understanding, what is the meaning of family planning?

    ---

2. What type of family planning methods do you use? (pills, contraceptives, nor-plants, condoms, etc)

   ---

3. Do you normally communicate with your spouse on the appropriate family planning methods? Give reasons for your answer

   ---

   ---

4. If yes in question 5 above, please state the various ways that are used in terms communicating with your spouse in relation to family planning methods

   ---

   ---

5. Do you normally accompany your spouse to the health facility for family planning education programmes? Give reasons or your answer

   ---

   ---

6. What is your opinion on the family planning methods that you are using?

   .....

   ---

7. What are the challenges that you normally face while using family planning methods?

   ---

8. What is your general opinion regarding the use of family planning methods?

Appendix III: Focused Group Discussion Guide

This is a focused group discussion guide. As a group, you will be asked number of questions by the interviewer. Please answer the questions as honestly as possible. Each one of you is expected to give your honest opinion about each question.

Section A: Demographic data.

1. Number of group members_____

Group composition indicating gender category

2. Gender category: Male_____

   Female_____

3. The group's understanding of family planning

   ---

4. Name the family planning methods that you normally use with your spouse (pills, contraceptives, nor-plants, condoms, etc)

   ---

5. Do you normally communicate with your spouse on the appropriate family planning methods? Give reasons for your answer

   ---

   ---

6. What are the various ways of communication used with your spouse in relation to family planning methods?

   ---

7. Do you normally accompany your spouse to the health facility for family planning education programmes? Give reasons or your answer

   ---

   ---

8. What is your opinion on the family planning methods that you are using?

   .....

   ---

9. What are the challenges that you normally face while using family planning methods?

Appendix IV: IREC Formal Approval Letter

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3
ELDORET
Tel: 33471//2/3

MOI UNIVERSITY
SCHOOL OF MEDICINE
P.O. BOX 4606
ELDORET

Reference: IREC/2015/18
Approval Number: 0001407

12th May, 2015

Ms. Anne K. Yano,
Moi University,
School of Public Health,
P.O. Box 4606-30100,
ELDORET-KENYA.

INSTITUTIONAL RESEARCH & ETHICS COMMITTEE
12 MAY 2015
APPROVED
P. O. Box 4606-30100 ELDORET

Dear Ms. Yano,

RE: FORMAL APPROVAL

The Institutional Research and Ethics Committee has reviewed your research proposal titled:-

"Gender Based Perceptions on Use of Family Planning among Marakwet Community in Koibarak, Elgeyo Marakwet County, Kenya."

Your proposal has been granted a Formal Approval Number: ***FAN: IREC 1407*** on 12th May, 2015. You are therefore permitted to begin your investigations.

Note that this approval is for 1 year; it will thus expire on 11th May, 2016. If it is necessary to continue with this research beyond the expiry date, a request for continuation should be made in writing to IREC Secretariat two months prior to the expiry date.

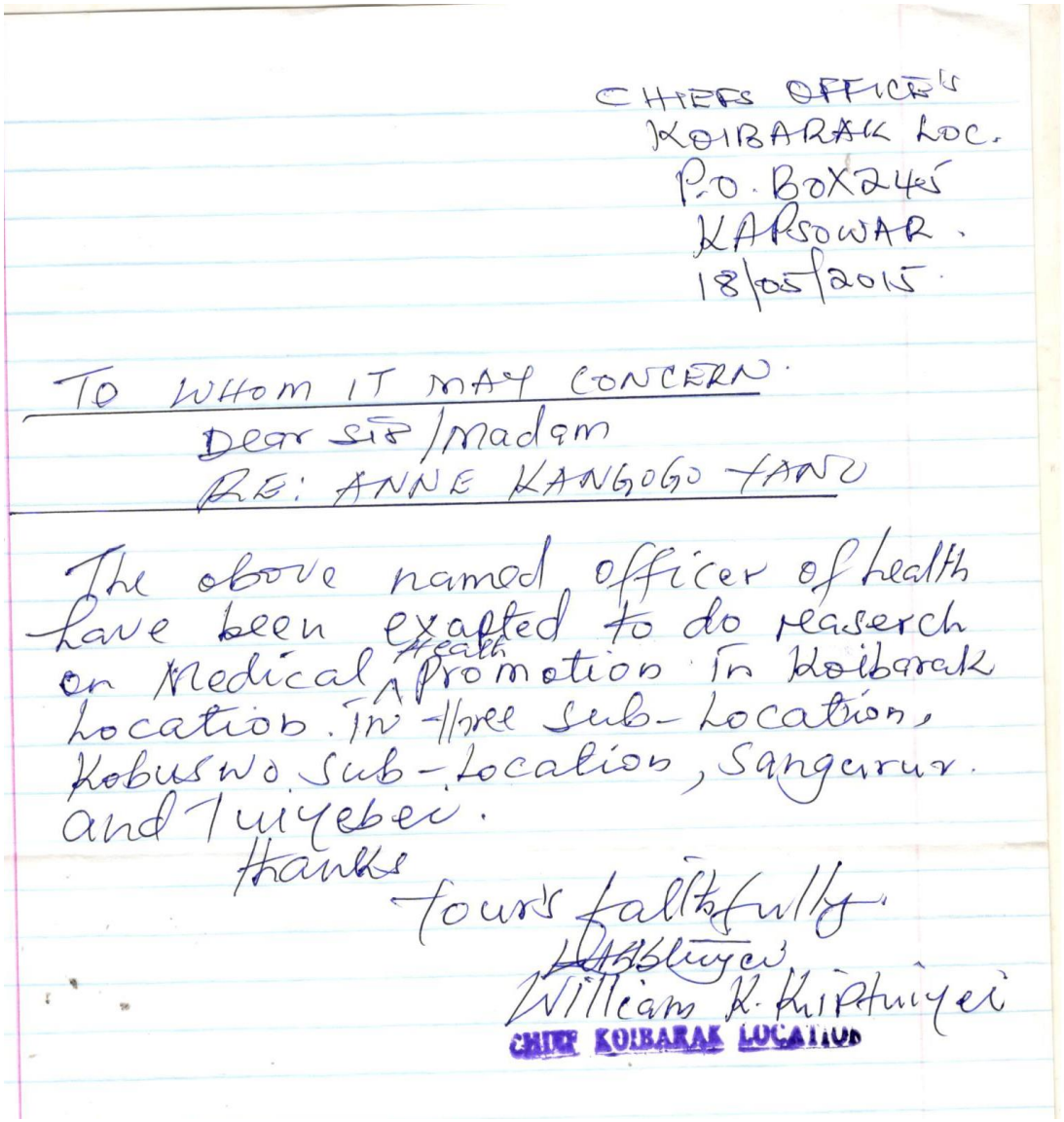
You are required to submit progress report(s) regularly as dictated by your proposal. Furthermore, you must notify the Committee of any proposal change (s) or amendment (s), serious or unexpected outcomes related to the conduct of the study, or study termination for any reason. The Committee expects to receive a final report at the end of the study.

Sincerely,

PROF. E. WERE
CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

cc Director - MTRH Dean - SOP Dean - SOM
Principal - CHS Dean - SON Dean - SOD

Appendix V: Chief Formal Approval Letter



CHIEFS OFFICE
KOIBARAK LOC.
P.O. BOX 245
KAPSOWAR.
18/05/2015.

TO WHOM IT MAY CONCERN.
Dear Sir/Madam
RE: ANNE KANGOGO TANUI

The above named officer of health have been exafted to do reaserch on Medical Health Promotion in Koibarak location. In three sub-Locations, Kobuswo Sub-Location, Sangarur and Tuiyebei.

Thanks

Yours faithfully.
William K. Kiptuiyei
CHIEF KOIBARAK LOCATION

Appendix VI: Elgeyo Marakwet County Map