THE PREVALENCE OF UPTAKE OF FAMILY PLANNING SERVICES IN MALINDI SUBCOUNTY, KENYA AND THE ROLE OF MALE SPOUSE INVOLVEMENT

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A Thesis Submitted in Partial Fulfilment for the Degree of Master of Science in Public Health (Epidemiology) of Pwani University

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Declaration

This thesis is my original work and has not been presented for a degree in any other university or any award.

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Dedication

This study is dedicated to women of Kilifi County suffering from the high unmet need for family planning.
Abstract
The contraceptive use prevalence rate in Africa at 31% still remains lower than that of the world, 63%. The rate of maternal mortality in the developing world is high where a total of 529,000 women die at childbirth due to pregnancy related complications each year. This has been attributed to the low level of utilisation of family planning (FP) of whose reasons vary from one context to another geographically. The study therefore sought to establish factors influencing utilization of FP services in Malindi Sub-county with an aim to establish the role of men in uptake of FP services. Using a cross-sectional study design, married women and men of 18-45 years residing within 2km radius of the health facilities were interviewed. Data was collected by interviewer-administered questionnaires, key informant interviews and focused group discussions.

The overall prevalence of utilization of FP services was 174 (53.0%). Awareness was established at 326 (92.4 %) on the modern FP methods for women. Several factors were associated with contraceptive use at bivariate analysis this includes age of respondents at category between of 30-40years (OR=0.56 CI: 0.56-0.98). This was protective in comparison to the younger couples of between 18-29years and more than 40years. The others factors were the level of education of respondents (tertiary level), type of marriage (Kadhi’s wedding and customary) and awareness on FP were associated with FP use at univariate analysis. A married woman whose husband is involved was 2.43 times more likely to use contraceptive than a woman whose husband is not involved (p value= 0.003) at univariate analysis. The main available contraceptive methods included pills, injectables, implants and male condoms. Utilization of FP services is low in Malindi sub-country, it was influenced by age, educational level, customary type of marriage and religion. Male involvement in FP remains low and was strongly associated with increased FP use. There is
need for increased promotion of family planning services targeting men including creation of male friendly centers.
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<thead>
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</thead>
<tbody>
<tr>
<td>CBOs</td>
<td>Community Based Organizations</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>FBOs</td>
<td>Faith Based Organizations</td>
</tr>
<tr>
<td>FGDs</td>
<td>Focused Group Discussions</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Council for Population and Development</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td>KNBS</td>
<td>Kenya National Beaurau of Statistics</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
</tr>
<tr>
<td>MDH</td>
<td>Malindi District Hospital</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Governmental Organizations</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population and</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children Education Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
CHAPTER ONE: INTRODUCTION

1.1 Background
The fertility rate in developing countries remains high at 4.7 according to the United Nations (UN, 2015). With a high population growth rate of 3 percent (UNFPA, 2011), developing countries have been projected to bear most of the adverse effects of overpopulation (Lutz et al., 2001). Despite the efforts to increase contraceptive use among countries the contraceptive prevalence rate, in Africa has been found to be very low at 31% and less than 21% in middle Africa, which is lower than that of the world, 63% (UN, 2013).

One of the consequences of low contraceptive use is the high rate of maternal mortality in the developing world which still remains high where it is estimated that a total of 529,000 women die at child-birth due to pregnancy related complications each year (UNICEF, 2010) which have been attributed to the low level of utilisation of family planning (Ronnsmans et al., 2006).

According to the UN, unmet need for family planning remains higher in the developing countries of the world (UN, 2013) where it is estimated that 25% of women of reproductive age who are married or in a union have an unmet need for family planning. Several studies across the globe have been carried out on factors that influence uptake of family planning services (Magadi and Curtis, 2003; Blacksone, 2016; Giusti and Vignoli, 2006; Faye et al., 2013; Calhoun et al., 2013). According to WHO, these have been summarized to into three delays, which are delay to seek due to socio cultural factors, delay to reach due to geographical factors and delay to receive quality services including commodities. The role of male spouse involvement as a factor varies in different contexts in Africa according to existing literature (Shattuck et al., 2011, Admasu et al., 2013, Godia et al., 2014). Therefore, appropriate and definite indicators of male involvement still remain varied in different socio economic contexts. Lakew and colleagues defined male involvement as
presence of the male solely during HIV testing (Lakew et al., 2013). This was used in a study on utilization of maternal and child health (MCH) services while specifically looking at prevention of mother to child transmission (PMTCT) of HIV in Sub Saharan Africa. Another study conducted by Shahjahan and colleagues on male participation in Bangladesh, found male’s involvement was defined as having spousal communication and accompanying wife to the clinic for reproductive health services (Shahjahan et al., 2013). In this study, they found that contraceptive use among men that came for evening clinics increased to 63% increased by 12% which is higher than the national figure of 51% (UN, 2012).

In Kenya, the contraceptive prevalence rate stands at 58% according to the Kenya Demographic and Health survey, 2014 (KNBS, 2015). On modern methods, the rate of contraceptives use stands at 53% nationally which is low compared to the contraceptive use prevalence rate of middle income economies, for instance South Africa, which stands at 60% (UN, 2013).

In Malindi Sub-County Hospital (MSCH), as per the health facility monthly reports, only two in 100 women currently using FP are accompanied by their spouses to the health facility for reproductive health services. Majority of men do not visit health facilities to seek FP services. There is therefore need to examine the factors affecting the utilization of contraceptives given the increased availability of modern methods in health facilities. The results hereof are expected to inform programmes in the area during campaigns aimed at promoting contraceptive use.
1.2 Problem Statement
The rate of contraceptive use in Malindi sub-county is low in comparison to the national rate. This may be associated with cultural, socio demographic and health care provider-related factors in supply side. The Ministry of Health in its strategy of availing the services of FP has tried to standardise accessibility throughout the sub-counties. Several choices and varieties of contraceptives have been availed in the whole sub-county but with low uptake. The low rate of uptake of FP has indicated a relation with a high fertility rate with subsequent high maternal and infant mortality rates (KNBS, 2015). With this high fertility rate (5.1), the majority of the residents have been affected by a poor quality of life (Sexty et al., 2016)

The knowledge on the factors associated with low contraceptive use in the sub county is scarce. The area is inhabited with various communities of diverse socio demographic characteristics. In addition, the role of male spouse involvement is still unknown in the uptake of family planning services among women.

1.3 Justification
To be able to increase the rates of FP utilization public health policy makers need to clearly understand the various demographic factors and the extent of their associated hindrance to utilization of FP in this region. Therefore, this study is timely to investigate the factors influencing uptake of FP including the role of male support and to recommend appropriate approach to promote and scale up uptake of FP.

1.4 Main Objective
The thesis reports on the current level of contraceptive use in Malindi sub-county among the married men and women of the ages of 18-45 years, factors that are associated with contraceptive use and the role of male involvement in the use of FP services.
**1.5 Specific Objectives**
1. To determine prevalence of FP uptake among married women and men of 18-45 years in Malindi subcounty.

2. To establish the factors affecting use of FP services among married women and men of 18-45 years in Malindi subcounty.

3. To establish the role of male spouse involvement in the uptake of FP among married women and men of 18-45 years in Malindi subcounty.

4. To determine the types of contraceptives available in Malindi Subcounty

**1.6 Research Questions**
1. What is the prevalence of FP uptake among married women and men of 18-45 years in Malindi Sub County?

2. What are the factors affecting use of FP services among married women and men of 18-45 years in Malindi subcounty?

3. What is the role of male spouse involvement in the uptake of FP among married women and men of 18-45 years in Malindi subcounty.

4. What are the types of contraceptives available in Malindi Subcounty?
CHAPTER TWO: LITERATURE REVIEW

There are varied definitions towards the concept of FP. The World Health Organization refers to family planning as the ability to attain a desired number of children in spacing and timing while many nations commonly refer to it as population control of fertility control (UN, 2015). Across the globe family planning is defined as the use of contraceptives. However, due to rights based approaches in health service delivery owing to improved sexual reproductive health rights in Africa and Kenya, the concept of family planning is viewed as having the number of children one is able to feed (UN, 2015). Increased uptake of FP services has been characterised by better maternal health outcomes (Koblinsky et al., 2008) however use of contraceptive is still a challenge in Kenya.

According to the KDHS 2014, the total fertility rate nationally stood at 3.9 however in Kilifi County was at 5.1 (KNBS, 2015). Furthermore, while in the country the contraceptive prevalence rate stood at 58% on the use of any method, in Kilifi County this was lower at 32.8% (KNBS, 2015). Knowledge on the factors influencing FP uptake in Malindi is low, while negative maternal health outcomes still remain to be associated with the high unmet need for family planning services. These negative outcomes are high maternal mortality ratio (695 in Kilifi County while nationally 405) and high infant mortality rate (44 in Kilifi County while nationally at 39.3), these factors have been found to be associated with low uptake of contraceptives. (Ronsmans et al., 2006). Another study by DeNavas-Walt (2005) has attempted to depict a picture where to maintain high health insurance coverage, and then the number of children born to a household should be commensurate with their economic status which was associated with having a smaller family size. According to the KDHS, 2014, this has further been associated with poverty as it was found out the household on lower wealth quintile had more teenagers starting child bearing early compared with households with higher wealth quintile.
In the advent of the Sustainable Development Goals, and the current renewed efforts towards resilience on climate change effects, Kenya is one of the countries that are to suffer the adverse effects of climate change by the year 2020 given the current rate of environmental degradation due to the high burden of population and the high growth rate. (Hutchinson and Agha, 2011)

According to the National Council for Population and Development (NCPD), the county seeks to reduce the Total Fertility Rate (TFR) from 4 to 2 by the year 2050 (NCPD 2014) so as to reduce effects of overpopulation, however FP use is still challenged by factors that cut across sexual reproductive health rights, lack of adequate supply of FP commodities and socio cultural practices (Kabagenyi et al., 2014). Unmet need for family which is the number of women who would like to practice family planning and are practicing it is influenced by several factors on access to commodities (Ali and Okud, 2013). Apart from availability of FP commodities in reducing the unmet need, initial reports have indicated that continued use of FP commodities among women can be maintained with support at household level (Alemayehu et al., 2012). In a study in Nepal by Adhikari, 2010, it was found out that utilization of FP services was influenced by age at first marriage, perceived ideal number of children, place of residence, literary status, religion, mass media exposure, household headship and having experienced death of a child.

Several contextual studies continue to be done to underscore the probable reasons for under-utilization of contraceptives. For instance, in Ethiopia, the factors influencing contraceptive utilisation were found to be wealth index, employed, educated, higher number of living children, attending community conversation and being in a monogamous relationship (Lakew et al., 2013).
One other factor that has been found to affect uptake and continued use of family planning services are the types of contraceptives. According to the Kenya Health and Demographic survey report of 2008/09, it was found out that perceived side effects was the main reason for discontinuation of FP use (KNBS, 2010).

In many communities in East Africa, issues of reproductive health are left to women. A study conducted in Sudan, by Scott et al., 2013 reported that communities believed that it was the responsibility of the women to avoid getting pregnant. This depicts a clear picture of very minimal involvement of men on family planning. This was further explored from a study conducted in the Democratic Republic of Congo, where it was reported that male involvement is an important pillar in the utilization of maternal child health services in general (Ditekemena et al., 2012).

In Ethiopia, couples that discussed family planning had higher uptake of contraceptives than those who did not (Mohammed et al., 2014). Apart from spousal communication, husband’s approval was found to be strongly associated with use of contraceptive. However, in Kenyan settings this may not be same since levels of literacy among women has gradually been increasing.

Male participation in family planning has been found to be the key pillars in the uptake and use of family planning services. In a study in Ethiopia by Tuloro (2006), it was found that the main reason for not using contraceptives apart from desire to have more children is opposition from husband. This is mirrored by preliminary case reports from female clients visiting dispensaries for FP services in Malindi subcounty. Male participation has been considered synonymous to male involvement. Similarly, Dietkemena et al., (2012), while studying determinants of male involvement in the utilization of MCH services, male involvement was defined as husbands’ presence during HIV couples counselling where spousal communication was highlighted as one of the key indicators of male participation.
A study in Bangladesh (Shahjahan et al., 2013) revealed that among couples where communication took place and the males agreed to visit the clinic together with his wife, contraceptive use increased to 63% from 51% among men.

Several factors have been found to affect male involvement in family planning given that they play a key role in decision making (Diro and Afework, 2013). In Madagascar, the key barriers among men to use of Family Planning included gaps in knowledge about contraceptive methods; dissatisfaction with some modern contraceptive methods; and concern about social opposition to using contraceptives (Randrianasolo et al., 2012). Two other studies in Africa on factors affecting uptake of reproductive health service continue to find male involvement in family planning as a significant factor (Eltomy et al., 2013; Mbando et al., 2011). Male involvement has been found to be affected by several factors including provider-associated barriers and cultural norms. In 2013, Akindele and Adebimpe conducted a study in South-western Nigeria on perceptions of care providers and found that the main barrier of male involvement is lack of accurate information on FP. Evidence of similar characteristics in Malindi Subcounty continues to be scarce. This suggests that different geographical areas have varied barriers to FP uptake and to male involvement which ought to be underscored for better programming.
CHAPTER THREE: METHODOLOGY

3.1 Study Design
A cross sectional study design was used. Both quantitative and qualitative data was collected. Cross sectional study design was considered appropriate since no study has been done in the area before and as such aimed at generating a hypothesis on the influence male involvement has on utilization of FP services.

3.2 Study Area
The study was carried out in Malindi Subcounty which is among one of the five sub counties in Kilifi County. The Sub County borders Kilifi to the south, Taita-Taveta to the west, Magarini to the northwest and the Indian Ocean to the east. It lies between latitudes 2.2\degree and 4\degree south and between longitudes 39\degree and 41\degree east (GoK, 2014).

Administratively the district has two divisions, Malindi and Lango Baya. These are further divided into 5 locations which are Malindi, Goshi, Ganda, Watamu and Gede locations in Malindi Division while in Lango Baya Division being Jilore, Chakama and LangoBaya locations (KNBS, 2010).

The population is estimated to be 287,670 people with females consisting of 52%. Out of this, the women of childbearing age (15-49 years) are 23% (66,739 people) while children under 5 years are 46% according to Malindi Sub-county Hospital annual report of 2014. The population of Malindi Subcounty is slightly cosmopolitan mainly composed of the Mijikendas around 70\%, followed by Swahili/Bajuni tribe holding about 15\% of the total population. Non-natives of the sub county comprise about 10\% of the total population and Europeans consist of a smaller number (5\%). The Language mostly spoken is Mijikenda and Kiswahili (KNBS, 2010).

The area is served by 82 health facilities, 20 of which are government facilities. These are distributed in each of the 5 locations where the most populated areas having more facilities
(see appendix VI- a map showing the distribution of the health facilities). The FP services available in the area include both client advice and provision of modern family planning methods.

### 3.3 Study Population

The study population comprised of married women aged between 18-45 years and married men between ages 18-45 years within 2km radius catchment of health facilities chosen in every ward in the study area. Health facilities in charges were also involved in the study for qualitative data. The target population was all married women men in Malindi Subcounty.

### 3.4 Sample Size

The formula below from Cochran (1963) was used to determine the number of participants.

The formula was found appropriate since the populations of the Sub county are large (greater than 10,000) and thus the study is leaned on the precision. This was determined as

\[
 n = \frac{Z^2 pq}{e^2}
\]

Where

- \(Z\) = Z value for normal deviate equivalent to 95% confidence level
- \(p\) = 30% (contraceptive prevalence rate for Coast province: KNBS2010, KDHS fact sheet)
- \(q\) = 1 - \(p\)
- \(e\) = level of precision = 5%

1.96 = standard normal deviate for 95% Confidence level

\[
 n = \frac{(1.96^2)(0.3)(0.7)}{(0.05^2)} = 323
\]

After adjusting for a non-response rate of 10%, a total 365 people were considered adequate for the study to yield a desired precision of 5% at 95% level of confidence. One third of the total size, 107 people, comprised of men while the remaining two thirds will comprise of women. This was because majority of those who will utilize FP services are women.

### 3.5 Sampling Technique

The sub county was divided into locations with health facilities determining where respondents were drawn from after which they were sampled proportionately in regards to the population size of the catchment areas. Proportionate sampling was used to distribute
the total sample size of respondents as per the populations of the 5 locations in the sub county. Once in the villages, a bottle was spin and the direction taken with systematic sampling being utilized to determine the 3rd household.

3.6 Data Collection Methods
Data collection was done using structured questionnaires(see appendix i) for quantitative data while four(4) key informant interviews with health workers (see appendix ii) and four(4) focused group discussions (see appendix iii and iv) with both men and women were used for collecting qualitative data. Data entry was done by use of EpiData software for quantitative data.

3.7 Data Analysis
From the quantitative data resulting from questionnaires, descriptive analysis was carried out to describe the results. Chi-square test was used to compare proportions and to check for statistical association and identify factors influencing contraceptive use. Bivariate and cross tabulation were used to identify the predictors of contraceptive use and assess the effect of male involvement in utilisation of FP services. A p-value of less 0.05 was considered significant. A statistical computer package R (R Core Team, 2013) was used to carry out the quantitative analysis. Logistic regression analysis was used to identify risk factors of contraceptive use and their impacts reported as odds ratios. Two multivariable logistic regression model were developed; i) included only variables that were significant in the univariate analysis at p-value<0.1 and ii) included all the variables in the univariate analysis. We tested the best multivariable model using likelihood ratio test and reported results of the model.

Content analysis and thematic coding was used to analyse qualitative data from the FGDs and the KIIIs. These were then used to corroborate both significant and non-significant associations from the quantitative data.
3.8 Pilot Study
A pilot of the study was carried out in Kakuyuni and Watamu locations to pretest data collection tools to inform of changes in the main study in terms of question formatting, areas of coverage and data entry techniques. The two locations were chosen since these have similar characteristics with study area. During this, 10% of the total sample size was pretested with.

3.9 Inclusion and Exclusion Criteria
The study included

1. Married women of ages 18-45 years willing to participate in the study
2. Married men of ages 18-45 years willing to participate in the study
3. Respondents residing within 2km radius of the chosen health facility (WHO)

The study excluded

1. Married women of ages 18-45 years not willing to participate in the study
2. Married men of ages 18-45 years not willing to participate in the study
3. Respondents residing more than 2km radius of the chosen health facility
3.10 Ethical Considerations
The study protocol was approved by Pwani University’s institution review board. Written informed consent was sought from participants before conducting interviews (see appendix iv). Data protection and confidentiality was ensured during data collection, entry and analysis.
CHAPTER FOUR: RESULTS & DISCUSSION

4.1 RESULTS

4.1.0 Baseline Characteristics
A total of 365 participants were recruited (table 1). Completed questionnaires were collected from 364 (99.7%). The mean age of the respondents was 30.5 years, with a range of 29.8-31.4 (95%CI). Of all the respondents, 181(50%) were below thirty of age while 155(36%) were between 30-40 years. Religiously, almost half 179(49.2%) were Protestants, 75 (20.7 %,) were Catholic, 69 (19.0%) were Muslim and 41 (11.3%) had responded to be in no religion.

Table 1: Baseline characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No(N=364)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>181</td>
<td>50.0</td>
</tr>
<tr>
<td>30-40</td>
<td>133</td>
<td>36.0</td>
</tr>
<tr>
<td>&gt;40</td>
<td>51</td>
<td>14.0</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestants</td>
<td>179</td>
<td>49.2</td>
</tr>
<tr>
<td>Catholic</td>
<td>75</td>
<td>20.7</td>
</tr>
<tr>
<td>Muslim</td>
<td>69</td>
<td>19.0</td>
</tr>
<tr>
<td>No religion</td>
<td>41</td>
<td>11.3</td>
</tr>
<tr>
<td><strong>Educational Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>40</td>
<td>11.0</td>
</tr>
<tr>
<td>Not Completed Primary</td>
<td>92</td>
<td>25.0</td>
</tr>
<tr>
<td>Primary Complete</td>
<td>102</td>
<td>28.0</td>
</tr>
<tr>
<td>Secondary incomplete</td>
<td>26</td>
<td>7.1</td>
</tr>
<tr>
<td>Secondary Complete</td>
<td>65</td>
<td>18.0</td>
</tr>
<tr>
<td>Tertiary</td>
<td>40</td>
<td>11.0</td>
</tr>
<tr>
<td><strong>Husband’s Level of Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>30</td>
<td>8.2</td>
</tr>
<tr>
<td>Not Completed Primary</td>
<td>67</td>
<td>18.0</td>
</tr>
<tr>
<td>Primary Complete</td>
<td>109</td>
<td>30.0</td>
</tr>
<tr>
<td>Secondary incomplete</td>
<td>27</td>
<td>7.4</td>
</tr>
<tr>
<td>Secondary Complete</td>
<td>94</td>
<td>26.0</td>
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<tr>
<td>Tertiary</td>
<td>38</td>
<td>10.0</td>
</tr>
<tr>
<td>Type of Marriage</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Customary</td>
<td>190</td>
<td>52.0</td>
</tr>
<tr>
<td>Come-we-Stay</td>
<td>67</td>
<td>18.0</td>
</tr>
<tr>
<td>Kadhi’s Wedding</td>
<td>54</td>
<td>15.0</td>
</tr>
<tr>
<td>Church Wedding</td>
<td>47</td>
<td>13.0</td>
</tr>
<tr>
<td>Civil</td>
<td>9</td>
<td>2.0</td>
</tr>
<tr>
<td>Form of Marriage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monogamous</td>
<td>333</td>
<td>91.0</td>
</tr>
<tr>
<td>Polygamous</td>
<td>32</td>
<td>9.0</td>
</tr>
</tbody>
</table>

**Types of marriages were defined as,**

- Customary: Traditionally settled union of marriage as per African cultures with respect to the couple’s tribes.
- Come-we-stay: As being agreement between two couples, male and female, and living together for more than 6 months preceding date of data collection.
- Kadhi’s Wedding: A marriage union that was officiated by a Kadhi.
- Church Wedding: A marriage union which was officiated by a Christian religious leader.
- Civil marriage: A marriage union which was officiated by a designated officer of the state (National government).

Many of respondents were those with complete primary schooling at 102 (28%), with the least being secondary incomplete, 26 (7.1%), as shown in Table 2. The mean number of children alive was 2.9 with the maximum number of children of 14 and minimum of zero in some households. Slightly more than half had been married was customarily at 190 (52%) followed by come-we-stay 67 (18%) Kadhi’s wedding, 54 (15%), then church wedding, at 47 (13%) and then civil-marriage at 9 (2%). The main form of marriage of respondents was monogamous 333 (91%) with polygamous at 32 (9%).
4.1.2 Objective 1: Prevalence of FP Use

Table 2: Shows Distribution of FP Use

<table>
<thead>
<tr>
<th>Variable</th>
<th>No(N=364)</th>
<th>(%)</th>
<th>No(N=364)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respondent's Level of Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>26</td>
<td>38.2</td>
<td>42</td>
<td>61.5</td>
</tr>
<tr>
<td>Not Completed Primary</td>
<td>15</td>
<td>68.2</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>Primary Complete</td>
<td>27</td>
<td>50.0</td>
<td>27</td>
<td>0.0</td>
</tr>
<tr>
<td>Secondary incomplete</td>
<td>50</td>
<td>52.0</td>
<td>46</td>
<td>48.0</td>
</tr>
<tr>
<td>Secondary Complete</td>
<td>7</td>
<td>26.9</td>
<td>19</td>
<td>73.1</td>
</tr>
<tr>
<td>Tertiary</td>
<td>39</td>
<td>44.8</td>
<td>48</td>
<td>55.2</td>
</tr>
<tr>
<td><strong>Husband’s Level of Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>8</td>
<td>61.5</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>Not Completed Primary</td>
<td>14</td>
<td>43.8</td>
<td>18</td>
<td>6.3</td>
</tr>
<tr>
<td>Primary Complete</td>
<td>35</td>
<td>52.2</td>
<td>32</td>
<td>47.8</td>
</tr>
<tr>
<td>Secondary incomplete</td>
<td>5</td>
<td>26.3</td>
<td>14</td>
<td>73.7</td>
</tr>
<tr>
<td>Secondary Complete</td>
<td>34</td>
<td>49.3</td>
<td>35</td>
<td>50.7</td>
</tr>
<tr>
<td>Tertiary</td>
<td>6</td>
<td>23.1</td>
<td>20</td>
<td>76.9</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>26</td>
<td>38.2</td>
<td>42</td>
<td>61.8</td>
</tr>
<tr>
<td>Protestant</td>
<td>70</td>
<td>42.7</td>
<td>94</td>
<td>57.3</td>
</tr>
<tr>
<td>Muslim</td>
<td>29</td>
<td>49.1</td>
<td>28</td>
<td>50.9</td>
</tr>
<tr>
<td>None</td>
<td>24</td>
<td>72.3</td>
<td>9</td>
<td>27.7</td>
</tr>
<tr>
<td><strong>Type of Marriage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church Wedding</td>
<td>13</td>
<td>29.5</td>
<td>31</td>
<td>70.5</td>
</tr>
<tr>
<td>Kadhi’s wedding</td>
<td>26</td>
<td>59.1</td>
<td>18</td>
<td>40.1</td>
</tr>
<tr>
<td>Customary</td>
<td>88</td>
<td>51.5</td>
<td>83</td>
<td>48.5</td>
</tr>
<tr>
<td>Come-we-stay</td>
<td>20</td>
<td>46.5</td>
<td>23</td>
<td>53.5</td>
</tr>
<tr>
<td>Civil marriage</td>
<td>2</td>
<td>22.2</td>
<td>7</td>
<td>77.8</td>
</tr>
<tr>
<td><strong>Form of Marriage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monogamous</td>
<td>136</td>
<td>45.5</td>
<td>163</td>
<td>55.5</td>
</tr>
<tr>
<td>Polygamous</td>
<td>13</td>
<td>54.2</td>
<td>11</td>
<td>45.8</td>
</tr>
<tr>
<td><strong>Male Spouse ever Accompanied wife</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>119</td>
<td>48.8</td>
<td>125</td>
<td>51.2</td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>28.1</td>
<td>46</td>
<td>71.9</td>
</tr>
</tbody>
</table>

*A variable for female respondents only*

The overall prevalence of utilization of FP services was established at 53 %( 174). This was distributed across the demographic characteristics of the respondents. Utilization of FP services increased with husbands’ education level and the highest utilization was at the
tertiary level (76.9%) while lowest utilization at those who responded as not having gone to school (38.5%).

According to religion, the highest utilization was found in protestant (54.3%) with the lowest being recorded among those with no religion (5.2%). Out of 364, a total of 259 (73.6 %) out of all the respondents had ever used a modern method.

**Level of Awareness on FP**

The study found that the level of awareness was 92% with respondents indicating that most information on FP was received from the health facilities, as shown in figure 1.

![Figure 1: Shows respondents’ source of information on FP services](image)

**4.1.3 Objective 2: Factors affecting use of FP**

Several factors came out to be associated with contraceptive use at bivariate analysis, as shown in table 3. Age of the respondents was found to be associated with FP uptake. The age bracket of 30-40years (OR=0.5, 0.56 CI: 0.32-0.98) had a lower positive influence on FP use in comparison to the younger couples of between 18-29years. Education of respondent (tertiary level), type of marriage (Kadhi’s wedding, customary) and awareness on FP come out to be associated with FP use at univariate analysis (*Table 3 below*).
Male spouse involvement was strongly associated with contraceptive use among women (OR= 2.43, CI: 1.29-4.71). During the FDGs the study found out that the main reasons for men not to get involved included not believing in FP, that FP is a woman’s ‘affair’ (men should not be involved) and they may regarded inferior by the community or peers and not accepted culturally. They also indicated that the methods have side effects.

While looking at the number of children alive that one had at the time of data collection, this was found that there was no association after adjustment.

The result from the unadjusted values was taken to multivariate analysis to determine how variables had effect on each other. Factors associated with contraceptive use in the multivariable regression model were; age 30-40 years (OR, 0. 56 (95% CI 0.32 to 0.98, P=0.04), Kadhi wedding (OR, 0.17 (95% CI 0.04 to 0.81), P=0.03) and having no religion (OR 0.35 (95% CI 0.12 to 0.98), P=0.04).

Table 3: Factors associated with FP Use at univariate analysis

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Categories</th>
<th>Crude OR (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>18-29</td>
<td>1.0</td>
<td>Ref</td>
</tr>
<tr>
<td></td>
<td>30-40</td>
<td>0.63 (0.39-1.01)</td>
<td>0.06</td>
</tr>
<tr>
<td></td>
<td>&gt;40</td>
<td>0.68 (0.36-1.30)</td>
<td>0.25</td>
</tr>
<tr>
<td>Education</td>
<td>None</td>
<td>1</td>
<td>Ref</td>
</tr>
<tr>
<td></td>
<td>Primary incomplete</td>
<td>2.25(0.93-5.42)</td>
<td>0.71</td>
</tr>
<tr>
<td></td>
<td>Primary Complete</td>
<td>2.47(1.035-5.893)</td>
<td>0.042</td>
</tr>
<tr>
<td></td>
<td>Secondary Incomplete</td>
<td>2.32(0.723-7.461)</td>
<td>0.157</td>
</tr>
<tr>
<td></td>
<td>Secondary Complete</td>
<td>1.839(0.736-4.594)</td>
<td>0.192</td>
</tr>
<tr>
<td></td>
<td>Tertiary</td>
<td>4.117(1.474-11.494)</td>
<td><strong>0.007</strong></td>
</tr>
<tr>
<td>Form of marriage</td>
<td>Customary</td>
<td>0.71(0.28-1.77)</td>
<td>0.412</td>
</tr>
<tr>
<td></td>
<td>Come-we-stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Civil Marriage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(polygamous/monogamous)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of marriage</td>
<td>Church Wedding</td>
<td>1</td>
<td>Ref</td>
</tr>
<tr>
<td></td>
<td>Kadhi’s Wedding</td>
<td>0.29(0.11-0.76)</td>
<td><strong>0.006</strong></td>
</tr>
<tr>
<td></td>
<td>Customary</td>
<td>0.396(0.194-0.804)</td>
<td><strong>0.0011</strong></td>
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<tr>
<td></td>
<td>Come-we-stay</td>
<td>0.734(0.314-1.716)</td>
<td>0.475</td>
</tr>
<tr>
<td></td>
<td>Civil Marriage</td>
<td>1.468(0.268-8.032)</td>
<td>0.658</td>
</tr>
<tr>
<td>Religion</td>
<td>No religion</td>
<td>1</td>
<td>Ref</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Categories</td>
<td>Adjusted OR (95% CI)</td>
<td>P value</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Age</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td>18-29</td>
<td>1.0</td>
<td>Reference</td>
</tr>
<tr>
<td></td>
<td>30-40</td>
<td>0.56 (0.32-0.98)</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td>&gt;40</td>
<td>0.61 (0.29-1.31)</td>
<td>0.21</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>None</td>
<td>1.0</td>
<td>Reference</td>
</tr>
<tr>
<td></td>
<td>Primary incomplete</td>
<td>1.53 (0.59-4.01)</td>
<td>0.39</td>
</tr>
<tr>
<td></td>
<td>Primary Complete</td>
<td>1.64 (0.63-4.28)</td>
<td>0.31</td>
</tr>
<tr>
<td></td>
<td>Secondary Incomplete</td>
<td>1.45 (0.41-5.09)</td>
<td>0.57</td>
</tr>
<tr>
<td></td>
<td>Secondary Complete</td>
<td>1.15 (0.40-3.32)</td>
<td>0.80</td>
</tr>
<tr>
<td></td>
<td>Tertiary</td>
<td>2.60 (0.77-8.79)</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>Type of marriage</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Church Wedding</td>
<td>1.0</td>
<td>Reference</td>
</tr>
<tr>
<td></td>
<td>Kadhi’s Wedding</td>
<td>0.17 (0.04-0.81)</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>Customary</td>
<td>0.48 (0.22-1.06)</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>Come-we-stay</td>
<td>0.80 (0.30-2.11)</td>
<td>0.65</td>
</tr>
<tr>
<td></td>
<td>Civil Marriage</td>
<td>1.81 (0.27-11.97)</td>
<td>0.54</td>
</tr>
<tr>
<td><strong>Religion</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Catholic</td>
<td>1.0</td>
<td>Reference</td>
</tr>
<tr>
<td></td>
<td>Protestant</td>
<td>0.89 (0.46-1.70)</td>
<td>0.72</td>
</tr>
<tr>
<td></td>
<td>Muslim</td>
<td>1.73 (0.44-6.78)</td>
<td>0.43</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>0.35 (0.12-0.98)</td>
<td>0.04</td>
</tr>
<tr>
<td><strong>Awareness on FP</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.14 (0.97-10.15)</td>
<td>0.06</td>
<td></td>
</tr>
<tr>
<td><strong>Male spouse involved</strong></td>
<td>1.88 (0.95-3.72)</td>
<td>0.07</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Multivariable logistic regression model with variables that were significantly (P<0.1) associated with contraceptive use was the best (P<0.0001).

4.1.4 Objective 3: Male involvement

Among those currently using FP, male spouse involvement was established at 26.9% who accompanied wife to the health facility.
Among the women, 78 (23.4 %) of respondents reported that they had never been stopped by their male husbands on FP use. In establishing spousal communication, a total of 283 (81.3 %) women stated they had at any time discussed FP with their spouse while 65 (18.7 %) had not discussed. Out of those who had discussed, 84.3 % (236) had reached an agreement while 44 (15.7%) did not agree. Thirty-one (13.5%) women reported that the mother-in-law had influenced them negatively from using FP. However, 181 (77.3 %) had never asked the husband to accompany them to the health facility. It was further established that 192 (83.1 %) women had never been accompanied by their husbands to the health facility for FP services. Reasons for husband not accompanying wife included: not believing in them, not accepted culturally, has side effects and others.

### 4.1.5 Objective 4: FP services available

From the qualitative data resulting from FGDs and KII with facility in-charges, the methods that respondents reported to be available to them were: pills, *injectables*, (this is a local term referring to the three month intramuscular injection, Depo Provera for women given) implants, and condoms. After further probing, among female respondents *injectables* were those that were mostly preferred and the reason given was the ability to conceal this FP from the husband. The long acting method available was vasectomy though no men were utilizing this method. Among the men, the main method of FP used was natural.

### 4.2 DISCUSSION

The mean age of respondents was found to be 30.5 years which was indicative that majority of the respondent were in the mid reproductive age. The age of respondents was found to be associated with contraceptive use at between 18-29 years. This may have been attributed to slightly higher literacy levels which has been associated with contraceptive use(Kura *et al.*, 2013).
While investigating for factors associated with higher FP use, type of marriage ($p$ value=0.007) was found to be associated where this was significant at customary type of marriage and Kadhi’s compared with the other types of marriages with church wedding being the reference category. This was due to the fact that most of the respondents were falling under the customary type marriage from the baseline characteristics. Education of respondent was found to be associated with utilization of FP commodities as was found out by other studies (Lakew et al., 2013), Only tertiary level and those who had completed primary school level of education were found to be associated with FP use (OR= 4.02 (1.32-13.08). This was attributable to a high level of awareness on FP (92%) among the respondents. This concurs with previous studies which have found that the higher the level of education the less number of children one would have (Michael, 2012). Generally, religion of the respondent was found to be associated with utilization of the FP commodities. If a respondent belonged to a religion, they were more likely to use FP than if they had no religion. Among the religions, highest utilization was found to be at protestant and Muslim type of religion because possibly because the faith did not specific have teachings against FP which was established during FGDs with women. Contrary to our finding, other studies reported FP uptake was highest among couples in customary type of marriage, since religion has been found to be an inhibiting factor in other communities (McQuillan, 2004; Mosher and Goldscheider, 1991). Prevalence rate of male involvement was found to be 26.9 which was attributable to the main sources of FP information being health facility yet the study established that majority of men do not accompany their wives to the health facility for contraceptive advice. This is further established by a study done by Akindele et al., 2013, who found out that lack of accurate information as one of the major reasons for non-involvement by men.
The Majority of the women reported that the husband did not stop them from using contraceptives. This was attributed to the fact that spousal communication was present with a high concordance level of 84.3%. This translated to a married woman whose husband was involved being 2.43 times more likely to use contraceptive than a married woman whose husband is not involved (p value= 0.003, OR=2.43 (1.29-4.71). This result was found to be congruent with previous study that showed husband’s approval was one of the major determinants of prolonged utilization of FP services by women (Mohammed et al., 2014). Contrary with other studies done elsewhere (Libbus and Kridli, 1997, Kadir et al., 2003), this study found that mother in law (mother to male spouse) did not have influence on contraceptive use by women (p value=0.326 OR=1.46 (0.64-3.44). Other studies attributed this to relatively improved literacy levels in the region (Fotso et al., 2013).
CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion
The study sought to establish the status of contraceptive use in Malindi Sub county among both men and women of 18-45 years. The rate contraceptive use was found to be moderately low at 53% compared with national figure which stands at 63%. It emerged that demographic factors including educational level at tertiary, and husband’s education level, religion were associated with contraceptive use. Other factors including influence by mother-in-law among women were found not to be significantly associated with FP uptake as have been found by other studies elsewhere. However, awareness on the modern types of contraceptive was found to be high among the respondents at 92% with their main source of FP information being from health facilities.

The study further sought to establish the role of male spouse in the use of FP services among their women. It was established that male involvement was associated with the using family planning with a strong statistical significance. Male involvement, which was measured as the rate of men accompanying wife to the health facility for FP services was low compared to national targets. However spousal communication was found to exist since the respondents reported that they had had a discussion on the subject of FP at household level.

Several types of contraceptive use were found to be available in the sub county, for both short term purposes and long term. Those available included pills, injections, implants, tubal ligation, female condoms, male condoms and vasectomy. However, utilization was found to be high on natural method among men while among women injections were more preferred and used than other methods. The study further finds that utilization of long acting permanent methods is still low.
5.2 Recommendations
Given the low rate of family planning use, even though services being available in across the sub county, there is need for increased promotion of family planning Services.

Since evidently men seem not to be involved in the reproductive health of the women in the Sub County, there is need for creating targeted messages and male friendly centers to attract men for family planning services.


Diro, C. W. and Afework, M. F. (2013). Agreement and concordance between married


APPENDICES

Appendix i. Respondents’ questionnaire
Location......................................... Questionnaire Code........................................

<table>
<thead>
<tr>
<th>Questions</th>
<th>Circle as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PART I: DEMOGRAPHIC CHARACTERISTICS</strong></td>
<td></td>
</tr>
<tr>
<td>Q1. Date of birth of respondent       Q2 Gender of respondent 1. Male 0. Female</td>
<td></td>
</tr>
<tr>
<td>Q3. Religion of respondent</td>
<td>Q4. Education level of respondent</td>
</tr>
<tr>
<td>1. Catholic</td>
<td>1. None</td>
</tr>
<tr>
<td>2. Protestant</td>
<td>2. Primary Incomplete</td>
</tr>
<tr>
<td>3. Muslim</td>
<td>3. Primary Complete</td>
</tr>
<tr>
<td>4. Other</td>
<td>4. Secondary Incomplete</td>
</tr>
<tr>
<td>5. Secondary complete</td>
<td>6. Tertiary</td>
</tr>
<tr>
<td>Q5. Spouse’s education level</td>
<td>Q6. No. of children alive.......</td>
</tr>
<tr>
<td>1. None</td>
<td></td>
</tr>
<tr>
<td>2. Primary incomplete</td>
<td>3. Primary Complete</td>
</tr>
<tr>
<td>4. Secondary incomplete</td>
<td>5. Secondary complete</td>
</tr>
<tr>
<td>6. Tertiary</td>
<td></td>
</tr>
<tr>
<td>Q7. Marriage type</td>
<td>Q8 Marriage form</td>
</tr>
<tr>
<td>1. Church wedding</td>
<td>1. Monogamous</td>
</tr>
<tr>
<td>2. Kadhi’s wedding</td>
<td>2. Polygamous</td>
</tr>
<tr>
<td>3. Customary</td>
<td></td>
</tr>
<tr>
<td>4. Come-we-stay</td>
<td></td>
</tr>
<tr>
<td>5. Civil marriage</td>
<td></td>
</tr>
</tbody>
</table>

**PART II: AWARENESS ON FP**

<table>
<thead>
<tr>
<th>Questions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9. Have you ever heard of family planning? 1. Yes 0. No (if no end there)</td>
<td></td>
</tr>
<tr>
<td>Q10. Where did you hear it first from?</td>
<td>Q11. When was the last time you heard FP?</td>
</tr>
<tr>
<td>1. Peer</td>
<td>1. In the last 48 hours</td>
</tr>
<tr>
<td>2. Parents/siblings</td>
<td>0. More than 48 hours</td>
</tr>
<tr>
<td>3. School</td>
<td></td>
</tr>
<tr>
<td>4. Mass media (radio, TV)</td>
<td></td>
</tr>
<tr>
<td>5. Health facility</td>
<td></td>
</tr>
<tr>
<td>Q13. Are you aware of the modern methods of FP for women? 1. Yes 0. No</td>
<td></td>
</tr>
</tbody>
</table>
Q.14 Please name them (*multiple response expected*)
1. Pills
2. Injections
3. Vasectomy
4. Female sterilization
5. Male condom
6. Female condom
7. Implants

PART III: UTILIZATION OF FP

Q.15 Have you ever used any method of FP
1. Yes  0. No  (*if yes skip to Q17*)

Q.16 Why haven’t you ever used?

Q.17 What methods did you use? (*multiple response expected*)
1. Pills
2. Injections
3. Vasectomy
4. Female sterilization
5. Male condom
6. Female condom
7. Natural

Q.18 For how long did you use this method?
1. More than 2 years
0. Less than 2 years

Q.19 Are you currently using any method of FP? 1. Yes 0. No (*if yes skip to 21*)

Q.20 Why did you stop using this method (*main reason*)
1. Had side effects
2. Wanted to have more children
3. Opposition from Husband
4. Other

Q.21 What method of FP are you currently using? (*only one response expected*)
1. Pills
2. Injections
3. Vasectomy
4. Female sterilization
5. Male condom
6. Female condom
7. Natural

Q.22 For how long have you been under this method?
1. More than 2 years
0. Less than 2 years

Q.23 Where did you access this from?
1. Health facility  
2. Shop/Chemist  
3. Other public place

Q.24 Do you intend to continue using this method?  
1. Yes  
0. No  
*(If no skip to Q.26)*

Q.25 For how long do you intend to continue this method?  
1. More than 2 years  
0. Less than 2 years

### PART IV: MALE INVOLVEMENT

Q.26 Has your spouse ever stopped you from using FP?  
1. Yes  
0. No

Q.27 Have you and your spouse ever discussed about use of FP?  
1. Yes  
0. No  
*(If no skip to Q.29)*

Q.28 Did you reach an agreement?  
1. Yes  
0. No

Q.29 Has your mother-in-law ever advised you against using FP?  
1. Yes  
0. No  
*(for women only)*

Q.30 Have you ever asked your spouse to accompany you to a health facility for FP advice or services?  
1. Yes  
0. No

Q.31 In the last one year, Has your spouse ever accompanied you to the health facility for FP services or advice?  
1. Yes  
0. No  
*(If yes skip to Q.33)*

Q.32 Are you able to cite probable reasons as to why your spouse has never accompanied you to the health facility for FP services/advice?  
1. Does not believe in them  
2. Not accepted culturally  
3. Has side effects  
4. Other.............................................. ................................................... .............................................. ...................................................

Q.33 In your opinion do you think that a husband has a role to play in the wife’s use of FP?  
1. Yes  
0. No

Q.34 What method of family planning does your husband use?  
*(for women only: multiple response expected)*  
1. Condom Withdrawal  
4. Vasectomy  
5. None

END  

*Thank you very much for your time and participation*
Appendix ii. Key informant Interview for Health Facility In-charges

Title: Factors Affecting the Utilization of Family Planning Services in Malindi/Magarini Subcounty

Principal investigator: Mr. Fredrick Majiwa, Pwani University.

Contacts: P.O Box 2007, Malindi, Cell Phone: 0718117034

Informed Consent: The enumerator to ask for consent from the participants

1. Do you approve of the use of family planning?
2. What are the types of modern FP available in the health facilities in this area?
3. What are some of the reasons that make women discontinue use of these methods?
4. In this area do men accompany their women to health facilities for advice or services on reproductive health?
5. In your opinion, why do majority of men in this area shy away from accompanying their women to health facility for advice on reproductive health?
6. In this area, is there an ideal number of children for a household?
7. Do majority of people practice family planning in this area? If no, what are some of the reasons that make households not to practice

Thank you for your participation
Appendix iii. Focused Group Discussion For men

Title: Factors Affecting the Utilization of Family Planning Services in Malindi/Magarini Subcounty

Principal investigator: Mr. Fredrick Majiwa, Pwani University.

Contacts: P.O Box 2007, Malindi, Cell Phone: 0718117034

Informed Consent: The enumerator to ask for consent from the participants

1. Do you approve of the use of family planning?
2. What are the types of modern FP available in the health facilities in this area?
3. Do men in this area accompany their women to health facilities for advice on reproductive health?
4. In your opinion, why do majority of men in this area shy away from accompanying their women to health facility for advice on reproductive health?
5. In this area, is there an ideal number of children for a household?
6. Do majority of people practice family planning in this area? If no, what are some of the reasons that make households not to practice

Thank you for your participation
Appendix iv. Focused Group Discussion for women

Title: Factors Affecting the Utilization of Family Planning Services in Malindi/Magarini Subcounty

Principal investigator: Mr. Fredrick Majiwa, Pwani University.

Contacts: P.O Box 2007, Malindi, Cell Phone: 0718117034

Informed Consent: The enumerator to ask for consent from the participants

1. Do you approve of the use of family planning?
2. What are the types of modern FP available in the health facilities in this area?
3. What are some of the reasons that make women discontinue use of these methods?
4. In this area do men accompany their women to health facilities for advice or services on reproductive health?
5. In your opinion, why do majority of men in this area shy away from accompanying their women to health facility for advice on reproductive health?
6. In this area, is there an ideal number of children for a household?
7. Do majority of people practice family planning in this area? If no, what are some of the reasons that make households not to practice

Thank you for your participation
Appendix v. Informed Consent

Title: Factors Affecting the Utilization of Family Planning Services in Malindi/Magarini Sub county

Principal investigator: Mr. Fredrick Majiwa, Pwani University.

Contacts: P.O Box 2007, Malindi, Cell Phone: 0718117034

Hi my name is.............................................................. We are doing a study in Malindi District

Purpose: The purpose of this study is to determine the factors influencing the utilization of family planning services in the district. The objectives will be to establish socio demographic factors, to determine the level of awareness, rate of contraceptive use and the role of male involvement in the use of family planning. This is ultimately aimed at informing programmes and projects in the area which are promoting use of family planning services, male involvement in FP and continued contraceptive to improve lives of the people.

You are expected to participate in this study for a maximum of 20 minutes.

Voluntary nature of participation in the study: Your Participation in this study is entirely voluntary. If you decline to participate, you shall not be discriminated against in any way and your decision shall be respected.

Procedure: Your participation in this study will involve answering a few the questions.

Confidentiality of Information: Utmost confidentiality will be observed in handling the information given. The information will only be used for the purposes of this study. The analyzed information and raw data will be safely kept under lock and key, only accessible to study staff.

Benefits: Participation in this study will not translate into any monetary benefits to the participants. However, the study will confer community benefits where your fellow residents will be informed on the dynamics of family planning and thus inform projects in this area on how to implement more effective FP services in this county

Risks: There will be no risks at all in participating in this study. Your name or identity or location will not be revealed anywhere.
Right to Withdrawal or Refusal: You may refuse to take part or withdraw from the study at any time.

Questions: In case of any questions, comments or complains regarding the study, kindly contact the investigators on the above address or the office of the DMOH.

PARTICIPANTS CONSENT

I declare that I have read the foregoing information or it has been read to me. I have had the opportunity to ask questions about it and any questions asked have been answered to my satisfaction. By signing below, I consent voluntarily to participate in this study described above, with knowledge that I can withdraw from the study at any time.

Participant’s Signature____________________  Date___________________