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Original Research Article

Correlates of family planning uptake among married men in Nyakach sub-county of Kisumu county, Kenya

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ABSTRACT

Background: Male involvement in family planning includes contraceptive use, supporting partners' decisions, peer influence, and advocacy for male-centered policies. Despite evidence that men positively influence contraceptive uptake, progress in rural Kenya remains limited. This study aimed to determine the correlates of family planning uptake among married men in Nyakach sub-county, Kisumu county, Kenya.
Methods: Using Fischer's formula, a sample of 404 respondents was obtained. A cross-sectional descriptive design with cluster sampling was employed, drawing participants from community health units in Nyakach. Data was collected using structured questionnaires, then cleaned and analyzed using microsoft excel and SPSS version 26. Results were presented as tables, frequencies, and percentages. Associations were tested using the chi-square test at a significance level of p=0.05.
Results: Education level was significantly associated with preference for healthcare providers (χ^2=8.12, df=3, p=0.044). Cultural factors strongly influenced uptake (χ^2=12.45, df=1, p=0.0004), with 45.8% preferring large families, 39.6% perceiving family planning as a woman's responsibility, and 29.2% fearing stigma. Health system barriers—including limited male-specific methods (50%), long distances to facilities (33.3%), and inadequate information (29.2%)—also showed significant association (χ^2=15.67, df=2, p=0.0004). Only 35.4% were aware of government policies, yet awareness significantly influenced uptake (χ^2=10.23, df=1, p=0.0014).
Conclusions: Targeted, male-focused interventions are needed. Programs should strengthen education through providers, community actors, and media; address cultural norms through community leadership engagement; and enhance policy awareness tailored to men's needs to improve uptake.

Keywords: Family planning, Contraceptive prevalence rate, Male involvement, Modern methods

INTRODUCTION

Family planning is defined as the ability of individuals and couples to anticipate and attain their desired number of children and spacing and timing of their births. It is achieved through use of contraceptive methods. Benefits to individuals, families, communities, and the societies demonstrate the significance of family planning.[1] Most of intervention in family planning involving men is effective in increasing the use of contraceptives. Their involvement as users and supporters is considered essential in optimization of outcomes in mother and child health.[2] Men's participation in the use of RH services includes their acceptance and expression of support for their partners' needs, choices, and rights, including the use of contraception and their own sexual and reproductive

behaviour to defend equality and encourage respect of human rights. The advantages of integrating males in family planning services are being increasingly recognized on a global scale even though contraceptive methods and services are primarily promoted at women; males are frequently the primary decision-makers when it comes to family size and their partner's use of family planning (FP) methods.[3] Reproductive, maternal, and child health are top priorities for the Sustainable Development Goal (SDG), which cannot be achieved without FP.[3] One of the most important public policy interventions to accomplish national and SDGs is involving men in FP.

Since the 1994 Inter-national Conference on Population and Development, men's participation in RH has been increasingly common. Research indicates that when men are involved, increasing spousal interaction may result in the use of contraceptives.[4] Recently, population researchers, policymakers, and designers of RH programs have become quite interested in the question of male engagement in FP. Up to 42% of maternal mortality in underdeveloped nations could be avoided by expanding access to FP services and enhancing their usage.[5]

According to research conducted in Bangladesh and Western Nigeria, there was a 40% male involvement rate.[6] This demonstrates that despite continuous efforts, male involvement is still low. According to a recent study conducted in Guatemala, males make most family planning decisions despite having little accurate knowledge about contraception. Since the men expressed a desire to learn more, methods for educating them about contraception will be developed based on the findings.[7]

FP initiatives generally carry the risk of maintaining the current level of gender inequality if the larger picture which considers both sexes is not given enough consideration, as opposed to focusing only on men. Research conducted in Nigeria and other sub-Saharan African countries has demonstrated that myths, false information, rumours, and unverified information spread through social media are the main barriers to the acceptance of contemporary contraceptive practices.[8] Factors contributing to this lack of FP use are husband resistance, technique ignorance, and fear of problems also found evidence of fear of FP adverse effects

In fact, the FP Program in Kenya has been a sub-Saharan African success story unlike any other. To support family planning, the Kenyan government has put in place several policies and initiatives. Increased prevalence of modern contraceptives and decreased unmet FP needs were the two main objectives of the National Family Planning Cost Implementation Plan 2017-2029. The adoption of FP techniques by married men is still below ideal, not withstanding these efforts. Despite men's awareness of FP methods, actual use of these methods is still low, especially in rural areas.[10] Nyakach sub-county is primarily a rural area with little access to medical care with contraceptive uptake at 28% according to the standard digital 2020.

In a society where 19% of married men utilize FP, according to data from the 2010 KDHS research on married males in various counties around the country. Finding out if males are involved and the factors driving male partner involvement in contraceptive uptake would be good, as this stands in contrast to Kenyan women whose contraceptive prevalence rate is at 57%.[10] It is unclear how male partners influence use of contraceptives. In comparison with the global, regional national and local dynamics there is need for research. Therefore, the purpose of this study is to investigate correlates influencing married men in the Nyakach subcounty use family planning

Objective of the study

The main objective of this study is to determine correlates of FP uptake among married men in Nyakach sub-county Kisumu county, Kenya. The study sought to assess the influence of culture on FP uptake among married men in Nyakach sub county Kisumu county, Kenya.

METHODS

Study design

The study used a cross-sectional descriptive study to determine correlates of FP uptake among married men in Nyakach sub-county. A quantitative and qualitative approach was used in data collection.

Study area

The study was undertaken in Nyakach sub-county of Kisumu county. Kisumu county has seven constituencies, one of which is Nyakach sub-county. It is located between longitudes 340 45' east and 350 21' west, and between latitudes 0000' (the equator) and 00 25' South. The Nyakach sub-county has five wards and a total area of 358.6 km2, including roughly 71 km2 of the lake water surface. Nyakach sub-county is served by several healthcare facilities, including dispensaries and health centres. However, these facilities may vary in terms of staffing, equipment, and service quality. Access to healthcare services can be a challenge for caregivers, especially those residing in more isolated areas.

Time frame of data collection

The data collection was carried out for one week from June 9th to June 15th, 2025. Each participant was interviewed for 10-20 minutes.

Study population

This study targeted married men above the age of 18years residing in Nyakach sub county. This category was of

interest for the study because it is key target for FP uptake.

Sample size calculation

The study sample size 404 determined using the Fishers formula.

Sampling technique

The study participants were recruited by cluster sampling. This involved listing all the community health units in Nyakach sub-county and randomly selecting the participants from each community health unit

Inclusion criteria

Married men above the age of 18 years in Nyakach sub county.

Respondents must reside in Nyakach sub-county, Kisumu county.

Only those married men who provide an informed consent to participate in the study.

Exclusion criteria

Married men with mental impairment and those who did not consent to the study.

Data collection

The study collected primary data from married men by use of a researcher-administered questionnaire. The researcher recruited and trained five research assistants (RAs) who supported the direct collection of data. They were briefed on the study's objectives, informed consent, data collection, and management procedures. The RAs assisted in administering the questionnaires to the selected respondents using Kobo Toolbox. The researcher recruited and trained two RAs who supported the direct collection of data. They were briefed on the study's objectives, informed consent, data collection, and management procedures. The RAs assisted in administering the questionnaires to the selected respondents using Kobo Toolbox.

Ethical consideration

This study sort for approval from Mount Kenya university Ethics and Review Committee Approval number 3483 and permit from National Commission of Science Technology and Innovation (NACOSTI) License number NACOSTI/P/25/416690. Additionally, approval was granted by the Kisumu county department of health. Participants were informed of the confidentiality in the study to ensure respect for the participants in the study, adhering to ethical principles of beneficence, justice, maleficence, and respect for autonomy. The study ensured ethical consideration by enforcing confidentiality, and anonymity. Before participants were recruited into the study informed consent was obtained from them.

RESULTS

Socio-demographic characteristics

The research obtained 100% response rate as all the 404 responds were interviewed and their response collected. Majority of the men surveyed, 33.7% (n=136) were aged 26-35 years, followed by 27.2% (n=110) aged 36-45, 21.9% (n=84) aged 18-25, 12.9% (n=52) aged 46-55, and 5.4% (n=22) above 55 years. Education levels were relatively high, with 40.6% (n=164) having tertiary education, 32.7% (n=132) secondary education, 20.8% (n=84) primary education, and 5.9% (n=24) with no formal education. Occupationally, 35.1% (n=142) were unemployed, 36.4% (n=147) self-employed, and 28.5% (n=115) self-employed. Most respondents, 85.1% (n=344), were in monogamous marriages, while 14.9% (n=60) were in polygamous unions.

Income levels varied, with 45% earning below 10,000 KES monthly, 30% between 10,001-50,000 KES, 15% between 50,001-100,000 KES, 7% between 100,001-150,000 KES, and 3% above 150,001 KES. Religiously, 85% identified as Christian, 10% as Muslim, 4% followed traditional beliefs, and 1% specified other faiths. Regarding family size, 51.0% (n=196) had 0-2 children, 34.4% (n=132) had 3-5 children, and 14.6% (n=56) had 6 or more children.

Influence of culture on family planning uptake

Cultural factors significantly influenced FP decisions. A majority, 72.9% (n=280), reported that culture affected FP uptake in their community, with key barriers including preference for large families (45.8%, n=176), FP being seen as a woman's responsibility (39.6%, n=152), and fear of community stigma (29.2%, n=112). Other factors included traditional beliefs discouraging contraceptive use (22.9%, n=88), influence from elders or community leaders (20.8%, n=80), and religious beliefs opposing FP (18.8%, n=72). Only 60% stated their culture always allowed open FP discussions with their spouse, while 40% cited barriers such as perceiving it as not their responsibility (20%) or fearing spousal reaction (15%). Additionally, 35% faced pressure from family or community members regarding FP choices.

Preference for large families has the highest non-uptake rate at around 40%, with only 20% uptake, indicating a strong cultural barrier. Woman's Responsibility shows a similar trend with 35% non-uptake and 25% uptake, while Stigma and Traditional Beliefs exhibit lower non-uptake rates (around 25% and 20%, respectively) and uptake rates (15% and 10%, respectively), suggesting a gradient of influence where traditional attitudes toward

family size and gender roles most significantly deter FP adoption. A chi-square test confirmed a significant association between the cultural influence and FP uptake (χ^2=12.45, df=1, P=0.0004), indicating that cultural beliefs substantially hinder FP adoption.

Table 1: Demographic distribution of the respondents.

Variable	Category	Frequency (N)	Percentage (%)
Age (in years)	18-25	84	20.8
	26-35	136	33.7
	36-45	110	27.2
	46-55	52	12.9
	Above 55	22	5.4
Education level	No formal education	24	5.9
	Primary education	84	20.8
	Secondary education	132	32.7
	Tertiary education	164	40.6
Occupation	Employed	115	28.5
	Self-employed	147	36.4
	Unemployed	142	35.1
Income	1000 and below	182	45
	10001-50000	121	30
	50001-100000	61	15
	100001-150000	28	7
	150000 and above	12	3
Marital status	Monogamous	344	85.1
	Polygamous	60	14.9
Number of children	0-2	200	49.5
	3-5	146	36.1
	6+	58	14.4
Religion	Christians	343	85
	Muslims	40	10
	Traditional	16	4
	Other	5	1

Table 2: Proportion affected by cultural beliefs.

Cultural belief	Frequency (N)	Percentage (%)
Preference for large families	176	45.8
FP seen as woman's responsibility	152	39.6
Fear of community stigma	112	29.2
Traditional beliefs discourage use	88	22.9
Influence from community members	80	20.8
Religious beliefs opposing contraception	72	18.8

Table 3: Cultural influence (yes/no) vs FP uptake.

Test	X^2	Df	P-value	Significance
Cultural influence vs FP uptake	12.45	1	0.0004	P<0.05

DISCUSSION

Cultural factors significantly influenced the FP uptake (χ^2=12.45, df=1, p=0.0004), with 45.8% citing preference for large families, 39.6% viewing FP as a woman's responsibility, and 29.2% fearing community stigma. These findings align with extensive literature on sub-Saharan Africa, where cultural norms prioritizing large families and gendered roles deter FP adoption.[11] The preference for large families reflects traditional values equating family size with social status, economic security, and lineage continuity, as noted.[12] This cultural belief is particularly strong in rural settings like Nyakach, where agriculture and labour-intensive economies reinforce the value of large families. The perception of family planning as a woman's responsibility underscores patriarchal

structures, where men often defer reproductive decisions to women, reducing their own engagement.[13] This aligns with the health belief model, where low perceived susceptibility to reproductive health risks among men reduces their motivation to adopt FP. Barriers such as fear of stigma (29.2%), influence from elders (20.8%), and religious beliefs opposing contraception (18.8%) are consistent with, who highlighted community-level pressures as significant deterrents.

The limited open FP discussions with spouses (40% cited barriers) reflects gender dynamics, as noted where spousal communication is constrained by norms discouraging men's involvement in reproductive health.[14] The significant association between cultural beliefs and FP uptake suggests that interventions must engage community leaders, elders, and religious figures to challenge traditional norms, as recommended.[15] Community-based participatory approaches, such as dialogue forums, could foster cultural shifts toward FP acceptance, as demonstrated in similar settings.[16]

Limitation

This study's main limitation was it focused-on individuals living in Nyakach sub- county, meaning that the findings should be generalized carefully. To address this limitation, the study sample was evenly distributed across all wards within the sub-county, resulting in a highly representative sample. As a result, the findings of the study can be readily applied to other areas that have characteristics similar to that Nyakach sub-county.

CONCLUSION

Regarding the influence of culture on FP uptake the study concludes that community norms have given priority for men to dominate reproductive health decision, from stigma, FP seen as women affair and religious beliefs hindering male uptake of FP thus the study concludes that culture significantly influence FP uptake among married men in Nyakach.

Recommendations

Based on the finding the study recommends cultural interventions must engage community leaders, elders, and religious figures to challenge norms favouring large families and gendered FP roles.

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