CHAPTER ONE

Introduction

Background

This study's goal is to provide insights into, as well as supplement existing knowledge regarding the partnership of husbands and wives in family planning and reproductive health. It will specifically examine the communication processes between husbands and wives, and their understanding of family planning with the intention of lending support to the prevailing emphasis by demographers and family planning programs on promoting partnership between men and women in the realm of reproductive health. The Men as Partners concept has become increasingly crucial to the overall success of family planning programs, particularly in patriarchal societies where men significantly influence decisions about family planning (Greene and Biddlecom, 1997; Blanc, 1996; Gachango, 1993).

Male involvement in enhanced reproductive health—be it through contraceptive use or positive partner participation—has remained low, despite the inception of family planning programs in most developing countries as many as three decades ago. This lack of male contribution has been attributed to the 'gender-biased' approach frequently adopted by family planning promoters in developing countries to the point that men have been referred to by some scholars as the "forgotten fifty percent" (see Stycos, 1996; Gachango, 1993) or, "the most powerful minority ever," (see Wilkinson, 1996)—a clear indication of the significance of the male's role in effective family planning.

The Program of Action adopted by consensus at the 1994 International Conference for Population Development (ICPD), expressed agreement that special efforts ought to be made to emphasize men's shared responsibility, and promote their active involvement in reproductive matters through condom use and or partner support—shifting the focus to partnership in family planning. Despite the fact that various studies (see Greene and Biddlecom, 1997) suggest that an emphasis on partnership in family planning is widely accepted in the demographic and reproductive health arenas, further examination of gender relations as they apply to reproductive behavior within specific target groups is imperative if such partnerships are to have a significant effect at both the research and the program levels.

The presence of communication and joint decision-making between couples has been identified as a substantial indicator of a successful partnership in fertility regulation. The actual occurrence of such partnerships, however, remains low when measured by quantitative survey (see Fapohunda and Rutenberg, 1999; NCPD and Macro International, 1999 Lasee and Becker, 1997; Greene and Biddlecom, 1997; Omwanda, 1996). An in-depth understanding of the subjective perceptions and communication processes is necessary in order to provide insights regarding potential behavior change. Greene and Biddlecom (1997) have noted that little research has been done to probe the motivations and resulting behaviors of the men and women involved in the process of family planning. While male approval has been widely documented, no comparison has been made between the motivations and involvement of men as opposed to women. Examining the ways in which this gender equation impacts how and why men become involved in reproductive health enhancement is a core focus of this study.

Although communication is generally perceived to enhance the occurrence of contraceptive use, there are many instances of a negative association between communication and contraception (Greene and Biddlecom, 1997) that reveal the need for a better command of the dynamics of couple communication. Thus while Coombs and Fernandez in Greene and Biddlecom, (1997: 30) refer to a high preference for fertility between husbands and wives in situations where communication is lacking, it is clear that communication alone cannot be un-problematically linked to contraceptive use among married couples (Greene and Biddlecom, 1997). An informed comprehension of the negotiation and communication process shared by men and women regarding reproductive health is required to bridge the gaps that exist between communication and contraceptive use.

Problem Statement

This study seeks to examine the perceptions of married men and women regarding family planning, and the dynamics of reproductive health communications between couples. The purpose of this investigation is to shed more light on which factors significantly affect the occurrence or absence of fertility regulation behavior between husbands and wives, with specific attention paid to their understanding of the concept of family planning, and the way they communicate about the issues.

A partner's influence has proven to be one of the variables that affects a woman's actual contraceptive use and unmet need for family planning (see Fapohunda and Rutenberg, 1999;

Biddlecom, and Fapohunda, 1998; Casterline, 1997 et al.; Lasee and Becker, 1997; Ngom, 1997; Becker, 1996; Toure, 1996, Blanc, 1996; Ezeh, 1993). While previous studies featured data collected from married women that depicted male attitudes as ambivalent and negative—leading to a breakdown in the women's demand for contraception (see Rono, 1998)—subsequent studies collecting data directly from men have shown increasing and prevalent positive attitudes towards family planning and contraceptive use on behalf of both men and women (NCPD and Macro International, 1999; Lasee and Becker, 1997; Becker, 1996; Chikamata, 1993; Ezeh, 1993).

The non-use of contraception in places where general demand is high is attributed to a lack of reproductive communication between partners. Various studies conclude that if partners communicated more with regard to family planning, the resulting positive attitudes would translate into increased contraceptive use (see Ngom, 1997; Lasee and Becker, 1997). As a result, programs that foster communication have been hailed as most likely to facilitate increased contraceptive use and further sustain or enhance the decline of fertility in places like Kenya. This study goes further, negating the widespread assumption of a linear positive relationship between spousal communication and increased contraceptive use. While communication is indeed important for spouses, and especially women, in the effort to enhance fertility regulation, empirical data reveals that high rates of communication between couples cannot simply be matched with contraceptive use at the individual couple level (NCPD and Macro International, 1999).

Western Province in Kenya, which houses the area under study, is one of the provinces behind the capital city of Nairobi and neighboring Central Kenya that is in a state of demographic

transition. While the province records relatively high fertility rates and low prevalence of contraceptive use, it is experiencing a considerable fertility decline that places it in the early stages of the overall demographic transition. The total fertility rate in Western Province has declined from 8.1 in 1989, to 6.4 in 1993, and 5.6 in 1998 (NCPD and Macro International, 1999; 1994). Combined with the 1998 KDHS provincial data citing increased family planning accessibility in the province and positive rates of declined fertility desires among men and women, the presence of a communication and contraceptive use paradox becomes more pronounced.

While communication between married spouses in Western Province is relatively high—40.7% of women report having discussed family planning more often than once or twice with their husbands—actual contraceptive use remains considerably low—21.9% for any modern method (the lowest in the country), and 32.4% unmet need (the highest in the country), (NCPD and Macro International, 1999). The questions persist: how does spousal communication effect contraceptive use? In what ways do dynamics like timing and partner attitudes influence practical reproductive outcomes? This study will provide insight into spousal approval or disapproval of family planning, their knowledge of contraceptive methods, perceptions held about their use, and elements in the social context that effect the way the concept of family planning is translated by both husbands and wives. Fully understanding the relationship between spousal family planning communication and subsequent contraceptive use is crucial for successful practical application, and justifies a comprehensive examination.

Research Objectives

To examine the ways married men and women understand of the concept of family planning, and their motivations for involvement.

To examine family planning communication processes in relation to contraceptive use among husbands and wives.

Rationale

This study recognizes the need to look at men as critical partners in fertility communication and decision-making. In many previous studies, husband and wife communication has been found to be the most significant indicator of contraceptive use. However, as previously noted, further research is needed for a better understanding of spousal communication regarding family planning in sub-Saharan Africa in particular (Lasee and Becker, 1997; Greene and Biddlecom, 1997). In most African countries, and in the study area specifically, the practice of family planning remains infrequent despite high knowledge and approval rates among both genders—leaving no clear understanding of how couple communication actually relates to contraceptive use.

Knowledge of modern contraceptive methods is as high in Western Province as in other surrounding regions (98.2% for women and 99.7% for men). In both cases, the province rates third highest out of seven others—all with well over 90% knowledge rates. Actual contraceptive use, however, remains low. Physical inaccessibility has been eliminated as an explanation for this scenario by the 1993 KDHS data which states that Western Province had the highest

percentage (33.3%) of respondents who cited the presence of a CBD (Community Based Distributor) in their area. Western Province also, however, presented the highest percentage of individuals who had never visited a CBD (18.6%). Western Kenya as a whole has the highest (26.1%) overall unmet need of family planning in comparison to the other provinces, and the lowest (6.2%) met need for spacing.

Western Province also has the highest percentage of husbands reported to disapprove of family planning. The gender aspect of fertility control therefore emerges quite strongly in this society (Republic of Kenya, 1994, Vihiga District Development Plan). A study examining husbands' roles in family planning is crucial in this community, where married men still assert a lot of influence on matters of family size. Focus group findings contribute to the existing body of knowledge on couples' family planning communication, as well as providing insights into how husbands and wives pursue fertility consultation and its impact on contraceptive use. This study covers types of communication processes, timing, contexts, and contraceptive use outcomes. These findings on spousal communication shed light on the prevailing ambiguities that appear when relating spousal communication to contraceptive use.

The specific timing of this study in a community where the demographic transition is perceived to be in the early stages with an expectation of continued fertility decline is particularly significant. A study that focuses on couple involvement in family planning matters provides insights for how programs can best achieve fertility regulation goals. At the practical level, this study can provide information which will assist programs in developing effective and relevant ways to intervene in couple counseling and enhance the communication around family planning.

Insights gained from this study will also help with the research and development of new technologies designed to address the various sources of contraceptive-related conflict, reducing discord between spouses in regards to method choice and family planning involvement. A blend of quantitative and qualitative data was used when examining the research questions, supporting a broader understanding of fertility regulation communication between married couples. This study will also address the implications of gender inequality and its effect on both the achievement of fertility regulation goals at the individual and couple level, and the enhancement of reproductive and general health for women and girls in developing countries like sub-Saharan Africa.

Issues of family size, fertility decision-making, and sexual behavior are traditionally male provinces in these cultures. In this study the relative male dominance within the sexual relationship and the resulting implications for fertility regulation and reproductive health are examined with the aim of providing further insight into the possibility of enhanced equality when dealing with partnership in family planning.

Despite the complexity inherent in engaging both genders in reproductive health the need for a better understanding of how these gender-relations operate within the socio-economic and cultural environments is significant for the enhancement of reproductive health. This study explores how the subjective reality experienced by both spouses informs and influences the negotiation, strategies, and outcomes with regard to the potentiality of partnership.

Lastly, a study that examines the process of family planning and contraceptive use among couples has implications in the enhancement of HIV/AIDS prevention and treatment. An informed look at contraceptive use in marital and extra marital situations, locally held stigmas surrounding condom use in marital relationships, and other factors surrounding the need for or lack of popularizing of condom use enhances our understanding of the complexity of HIV/AIDS prevention in such contexts. The insights into fertility preferences and negotiation strategies at the individual and couple levels provided by this study have direct significance for increasing the effectiveness of HIV/AIDS prevention.

Structure of the Dissertation

This dissertation is divided into eight chapters, including the introduction, which serves as the first chapter. A wide range of literature is reviewed in the second chapter, including studies linking socio-economic and cultural factors to fertility regulation. The chapter also reviews literature that presents more recent challenges and insights into linking socio-economic and cultural environment to the fertility regulation practiced by individuals and couples. An examination of couples' family planning communication is undertaken in the second chapter.

Chapter three provides the conceptual framework for the examination of couples' understandings of family planning and spousal communication that shapes the thesis. It outlines the key concepts involved in the cultural and political economy of fertility framework, and discusses the application of each as it applies to perceptions of family planning and spousal interaction, as well

as actual contraceptive use. Chapter four presents a description of the study site, the population of the area, and its socio-economic set-up.

Chapter five provides details on the data and methodology used in this study, and how the analysis of both quantitative and qualitative data was undertaken and integrated in my efforts to answer the objectives of the study.

The study's findings are presented in chapters six and seven. Chapter six features an examination of spousal understanding in regards to family planning, including their approval, knowledge, motivations, and contraceptive use. Chapter seven provides an explanation of the communication processes between husbands and wives that notes the specific implications of the outcomes of contraceptive use or non-use. The dissertation closes with conclusions and recommendations for program development and future research in chapter eight.

CHAPTER TWO

Literature Review

Introduction

Demographic studies have addressed the issue of fertility regulation largely by examining women's—and more recently men's—family size preferences, attitudes towards contraceptive use, and the surrounding socio-economic and cultural dynamics. In sub-Saharan Africa the observed changes in demand for Family Planning alongside programmatic efforts that increased the supply of contraceptives for communities in the urban and rural areas have been used to explain the remarkable fertility decline noted in countries such as Kenya and Zimbabwe (Bongaarts, Mauldin and Phillips, 1990).

The existing socio-demographic literature in Kenya describes a high demand for fertility amidst the prevailing pro-natal socio-economic and cultural environment to explain what was once noted as the highest fertility rate (8.1) in the world. The subsequent fertility decline is attributed to a widely noted decrease in demand for large family size, and an effective fertility regulation supply system—secured by a widely hailed family planning program and significant rise in contraceptive use (NCPD and Macro International, 1999; 1994; African Population Policy Research Center, 1998; Fapohunda, 1998; Kekovole, 1998).

This study does not cross-examine the argument of whether supply or demand factors are responsible for fertility decline. Instead the focus will be on developing an understanding of the dynamics surrounding fertility demand, with an emphasis on the follow-through experienced by

husbands and wives. While the complex nature and significance of examining structural factors through demographic studies is appreciated, gaps inevitably open between such studies, and the need for a broader examination of fertility demand and behavior that employs the political economic framework is recognized.

This study springs from the notion that in order to understand family planning and the ways couple communication and decision making are involved one must examine the concept of fertility demand as it is handled in the relevant literature. Such an examination uses both demography and cultural anthropology to note various weaknesses in relation to evidenced fertility behavior, while underlining the relevance of examining fertility demand from the perspectives of husbands and wives and their own comprehension of family planning, also taking into account the implications of their fertility regulation motivations and strategies.

Demographic literature that places an emphasis on the influence of socio-economic and cultural factors on changing pro-natal culture, and thus fertility demand, is reviewed first. Traditional African values have been described as ideologically pro-natalist, and the existence of various structures that persistently support the pro-natalist norms and values have been identified by various scholars as obstacles to the success of family planning programs—particularly in so far as they affect the demand for children (Ocholla-Ayayo, 1991; Caldwell and Caldwell, 1987).

The first section examines how local social structures including family systems, land tenure practices, and children's contributions are treated in the demographic literature on fertility demand. The section underlines the limitations inherent in an understanding of fertility demand

based solely on attempts to link structural factors to behavior, and the normative treatment of culture in the reviewed literature. Emphasis is placed on the ways that an individual's social-cultural and political-economic backgrounds inform their reproductive values and motivations for reproductive behavior. The restrictions that exist when relating socio-economic and cultural factors to fertility at the aggregate level are noted here, and the importance of expanding the literary field is emphasized.

The structural argument provided in most traditional demographic literature reviewed here presents inconsistencies in empirical evidence, and is seen to be aligned with the long-disputed demographic transition theory. This theory, however, has been criticized for speculating the economic transition and fertility decline for all societies using a high-to-low path, as well as acting as a proponent of the modernization theory and its ethnocentric ideas—ideas that are inapplicable to other developing countries like Africa (see Greenhalgh, 1990).

Much of the demographic work linking community structures to fertility demand has also been criticized for drawing on structural-functionalist traditions in anthropology (popular in the 1940s and 1950s) in its treatment of culture, resulting in a depiction of culture as normative and prescriptive when explaining fertility behavior. One problem with this type of approach, as pointed out by various demographic or cultural anthropologists (Hammel and Friou, 1997; Kertzer and Fricke, 1997; Lockwood, 1995; Hammel, 1990, Greenhalgh, 1990), is its failure to conclusively establish links between social structure and norms, and between norms and actions, while appropriately accounting for the clear inconsistencies—delivering a limited account of the ways in which individuals and groups engage with cultural values. There is a growing

acceptance among demographers that paying attention to culture-related micro level analysis will result in a more complete understanding of fertility behavior (see Greenhalgh, 1990).

This study goes beyond contemplating fertility regulation from an aggregate perspective. Given that the concentration is on married couples, literature examining the influence of spouses, family, and the community is vital. The second section of the literature review re-examines the implications of socio-cultural environment on fertility behavior, underlining the significance of gender differences, networking, and heterogeneities. Said literature uses micro-level studies to shed further light on the dynamics of individual and group interactions with varying community, cultural, and social environments when defining, strategizing, and implementing reproductive behavior (see Watkins, 2000; Bledsoe and Hill 1998; Bradley, 1995; Bledsoe, et al., 1994).

Lastly, the literature review addresses the significance of couple interaction within the social, economic, and cultural environment in shaping the formation of fertility preferences and desired fertility regulation behavior, and influencing the complexity of negotiation between spouses regarding family planning.

Linking Structural Factors to Fertility Demand

Although the contextual environments that spouses operate in begin to provide the underlying scenario upon which fertility demand is realized, the complexity of relating this information to seemingly inconsistent behavior must be explored. This section examines fertility demand as it is

treated in the traditional demographic literature, which links fertility demand to structural factors, while noting the inconsistencies and weaknesses present when making this connection.

In sub-Saharan Africa, the three most important socio-economic factors traditionally related to changes in fertility demand include systems of family organization, land tenure and holdings, and the family contributions of children. Specifically, these structures have been said to promote high fertility among traditional African communities, and today among communities in rural areas (Ochola-Ayayo, 1991; Boserup, 1989; Frank and Mc Nicoll, 1987; Frank, 1987; Caldwell and Caldwell, 1987, 1985).

Literature examining the socio-cultural structures and institutions of the communities under study is largely "old", offering limited practical applicability to the contemporary communities—even in rural environments. However, examining said literature—particularly with regard to the changes that have occurred—can provide a sense of the local set-up in current rural Kenya as well as raise important questions about fertility regulation demand and behavior among couples in those areas. An examination of family systems including patriarchy, polygamy and conjugality, land resource holding, and the family contributions of children is key in comprehending the overall fertility behavior of the married couples involved.

Family Systems and Implications for Fertility Demand

Family systems as used here refer to forms of organization such as patrilineal systems, marriage types, and polygamous or monogamous spousal relations. "African family lineage systems are arranged on a continuum that ranges from simple and cohesive to complex and tight, in terms of interpersonal relationships" (Radcliffe and Forde, in Kalu, 1981: 350). Varieties of both

patriarchal and matriarchal family systems have been identified among communities in Africa in general, and East Africa in specific. In fertility studies, the topics of marriage and family systems in Africa have received attention mainly in relation to explaining fertility demand and the absence of fertility regulation. The aspects of family systems associated with fertility demand and regulation in sub-Saharan African communities include lineage systems, polygamy, and the notion of separate gender roles for husbands and wives (Mburugu, 1994; Ochola-Ayayo, 1991; Frank and Mc Nicoll, 1987; Frank, 1987; Caldwell and Caldwell, 1987, 1985).

An emphasis on the role lineage plays in the enhancement of large family values among communities in Africa dominated demographic literature in the 1980s, when fertility figures reached their peak in sub-Saharan Africa (Safilios-Rothschild and Mburugu, 1994; Ochola-Ayayo, 1991; Caldwell, 1987; Frank and McNicoll, 1987). The increased value of a large family within patrilineal communities—particularly before the onset of fertility declines in the 1990s in parts of Africa, including Kenya—was attributed to lineage systems that placed importance on the continuation of the family line via the accumulation of male children in patrilineal communities. Caldwell and Caldwell's 1987 West African literature underlined the pro-natalist nature of African communities, and underscored the influence of lineage succession on the desirable nature of large family size in African communities.

The prevalence of lineage-based systems in African communities has been identified as a main reason for the persistence of high fertility in sub-Saharan Africa and Kenya, even in the face of vigorous family planning programs. Various demographers have explained how 'the fear of family extinction' has become deeply rooted in the African population (Ocholla-Ayayo, 1991;

Caldwell, 1987). According to Molnos' (1973) writing on the desire for numerous offspring in East African communities, "the paramount objective of having children was that there should always be a living descendant to remember and honor the departed. Children meant the continuation of the lineage and the perpetuation of the family name and spirit. Descendants were needed to perform funeral ceremonies, to ensure that the parents, unlike childless people, be buried and that the ancestral spirits be commemorated by erecting shrines, pouring out libations and offering food" (Molnos, 1973: 8).

Frank and Mc Nicoll (1987)—in their efforts to explain Kenya's high fertility—concluded that the persistence of traditional socio-cultural patterns including marriage and the control of resources were the underlying reasons for the apparent unresponsiveness of African fertility to circumstances that might have been expected to depress it at the time (Frank and McNicoll, 1987: 213). They noted that marriage in Kenya was traditionally, and in considerable measure remains, a form of contract between two lineages rather than a direct commitment between husband and wife. The bride-price paid by the husband's lineage in Kenyan communities entitles the husband to the children borne by the wife. Among the Luhyia, children belong to the husband's lineage and male members of the family and, when grown, are specifically responsible for the continuation of the linage by marrying and having more children. The rights of the husband's lineage over the children can be so exclusive that in cases of divorce, mothers who move away must leave their children behind (Lukalo, 1973).

Knappert (1987:11) provides evidence of the significance of ancestry worship and lineage enhancement among the traditional Luhyia, illustrated by naming ceremonies and the importance

of naming the departed to ensure their continuation in the children borne. The lineage structure organization maintained both age and gender hierarchies. Younger family members were expected to obey and respect older persons, and the oldest male in the family held the role of decision maker (Knappert, 1987:11). Caldwell (1987) noted that the ownership of the family resources was only released from father to son after the son had started his own family.

The significance of expanding lineage through large family size is also explained in political and economic terms. Large family sizes also meant an expansion of the protection from neighboring communities provided by numerous relatives, as well as an increase in the communally owned property. Children provided the labor for working the free land holdings accessible for use by lineage members, so more children meant more land was able to be cultivated to yield produce both for subsistence, and for trade. As Caldwell and others noted, large family sizes were both rational and advantageous in this environment. Despite contrary historical evidence offered by Watkins (2000) refuting this notion of abundance in the past, the fact that large family sizes have been traditionally desired has had incontrovertible influence on fertility behavior in these situations.

Another social factor that has enhanced the desirability of large family size is the perception that large families offer increased social status for both husbands and wives. Men with more wives and children gained respect in the community, while women were expected to bear children to support their husbands' lineage as part of what is understood as the marriage contract. Molnos noted (1973) that community customs pointed to the fact that child bearing was one of the most important issues in the traditional societies of East Africa, and certainly the most important in

every woman's life since her social status increased with the number of children she was able to bear for her husband (Molnos, 1973: 55). Failure to bear enough children was seen as a breach in the fulfillment of the marriage contract, and invited scorn and the stripping of status for the woman (Lukalo, 1973; Goody 1989; Livingstone, 1989; Boserup, 1989; 1985; Galor and Weil, 1996). Among the Luhyia, as in other East African communities, barrenness would result in separation, divorce, or the husband marrying other wives. A woman's status within society becomes significantly related to her family size, thereby reinforcing high fertility values (Lukalo, 1973).

While lineage issues have a clear influence on high fertility demand, fertility in 1980s Kenya (about eight children per woman) was even higher than it had been in the 1950s and 1960s, (about six and seven children per woman) despite active social efforts to curb fertility (see Dow and Werner, 1982:17; Kenya, Central Bureau of Statistics, 1980 and 1984:61 in Frank and McNicoll, 1987: 212). Although modernization had made its mark in both rural and urban areas, high fertility was not a clear component of the traditional African family (fertility was checked somewhat by cultural practices such as breastfeeding and periodical sexual abstinence for mothers). It appeared to be a combination of cultural practices and socio-economic changes affecting the communities in colonial times, during independence, and beyond (see Watkins 2000; Dow et al., 1994).

In relation to the family systems examined above, while the Luhyia have—along with other African communities—been dubbed pro-natal, it is interesting in the advent of fertility decline to observe how family systems and values have persisted or been discarded within a changing

socio-economic environment at the community level, and examine how couples seek to make sense of the notion of fertility control within an environment where traditional and modern practicality provide a mix of influencing factors.

Polygamy and Fertility Implications

The existence of polygamy in African families has been examined in relation to lineage structure and practices, fertility, and fertility regulation. The relation of polygamy to fertility issues varies among the available literature. Frank and McNicoll, writing in 1987, reported that polygamy was still prevalent in Kenya, but their evidence dates back to the 70s (almost a third of married women nationally were in polygamous unions in the late 1970s [Kenya Bureau of statistics, 1980] allowing husbands to gain rights over larger numbers of children [Frank and McNicoll, 1987: 214]).

In Kenyan patriarchal communities, wives symbolized wealth—both in terms of the man's ability to provide bride-wealth for several women, and increased labor provided by women and children that enhances the family wealth while ensuring a continued lineage. As a result, more wives translated into increased social status, and polygamous marriages—particularly within communities that practiced crop farming in a free-land holding system—supported the rising demand for fertility in sub-Saharan African communities (World Bank, 1990; Frank, 1987; Caldwell, 1987).

The practice of polygamy is well suited to the above-mentioned economic and cultural environment. It also supports the practice of post-partum abstinence, allowing the husband to

engage in sexual relations with other wives while one is in abstinence following the birth of a child. Some studies in Kenya have linked the reduction in polygamy over time to increased levels of poverty. Most young men were not accruing the wealth necessary to support multiple wives thanks to reduced family income as a result of the subsistence farming of small land holdings (Mburugu, 1994). Goody (1989) indicates that while a lack of education is often cited as a reason for reduced polygamy, some schooling—including primary and secondary education—appears to relate to a general increase, rather than a decrease in polygamy.

Other studies report limited links between polygamy and fertility, especially at the individual level (see Mulder, 1989). Mulder's study of the Kipsigis (a rural, Kenyan, agro-pastoralist population) reveals that while the instance of polygamy was high (78 to 88% of the 1,192 married women interviewed were in polygamous relationships), the reproductive performance of the women remained low as a result of child spacing practices and family living arrangements that reduced competition between wives (Njogu, 1991). The occurrence and extent of polygamy among specific communities even within shared regions appears to vary significantly. Among the Maragoli (a sub-tribe of the Luhyia) in Western Kenya, literature reveals low rates of polygamy usually practiced due to specific factors like barrenness of the first wife, the birth of only one gender, ill health, and the inability to fulfill wifely roles—including child bearing and rearing (Lukalo, 1973). The significance of the presence of polygamy on fertility at the individual level is therefore less significant in societies like these. More recent literature provides data that suggests that the decline in polygamy is largely linked to the prevailing changes in the socio-economic set-up and the cultural norms that go along with the practice, as well as to the spread of both Christianity, and education (see Mburugu, 1994; Goody, 1989).

The decline of polygamy in the face of socio-economic changes in Kenya was noted as early as the 1960s. Although the role of Christianity in undermining the polygamous family is noted, socio-economic changes provide significant insight into the overall decline. Molnos' (1973) work on attitude changes in family planning concluded that the need for economic adaptation has undermined the traditional basis of compound polygamous families in towns and urban centers, while limited land resources have led to the rationalization of fewer or one wife in rural areas (Mburugu, 1994; Robinson, 1992). The costs of polygamy were also related to colonial policies like the hut tax in Kenya which deliberately interfered with the organization of the traditional African family. Payment for more wives (in multiple huts) made the traditional practice uneconomical (see also Thurnwald, 1932). Although this did not do away with polygamy altogether, Timeus and Reyner (1998) examined polygamy in Ghana, Senegal, Uganda, Zambia and Kenya, concluding that polygamous marriage is clearly in the most rapid decline in Kenya.

It is important to take the presence of polygamy into consideration when examining how couples practice fertility regulation, communication, and decision making. In many quantitative studies where men have provided answers to questions relating to their fertility preferences, it must be clarified which partner they are referring to. As a result, polygamy becomes an important factor in understanding what may otherwise be identified as "partner disagreements". Qualitative data provides insights into how both husbands and wives make sense of fertility regulation, as well as their perceptions regarding their involvement in polygamous relationships or "potential" polygamy. With this in mind, it is vital to note that the fact that the practice is on the decline does not cancel out its implications for fertility regulation.

Couple Conjugality, Fertility Demand, and Decision Making

Another aspect of family organisation in most traditional African patriarchal communities is the limited conjugality between a husband and his wife or wives, in relation to enhancing lineage allegiance. Couple conjugality here refers to the perceived primary partnership of husband and wife, exemplified by co-residency, partnership in fulfilment of various roles, and limited influence from extended family. The patrilocal residential arrangement (where the marital residence is at the husbands' home compound) within the patriarchal set-up presents a marriage structure in which husbands and wives function under the auspices of the husband's parents, sharing the homestead compound with his family and recognising the patriarchal figure of the husband's father as the overall family head. The prevalent extended family structure in Africa is reported as one which undermines the conjugality between husbands and wives, because the power rests with the patriarchal authorities of the extended family whose interests in lineage enhancement through large family size prevail (Caldwell, 1987).

Looking at conjugality among the Luhyias, the sons traditionally built a hut behind their mother's house upon reaching adolescence then obtained land to build a house within the family homestead shortly after getting married. The wife was brought into the husband's homestead, and typically lived in the in-laws' house until the husband's home was finished. The couple's children belonged to the father's lineage, and his extended family exhibited considerable power in terms of child rearing. The wife not only became an additional member of the husband's family, but also maintained close links with her in-laws in terms of a "shared" residence, expected labor input, and family welfare. These responsibilities included working on the family

land, cooking, and doing other chores together with the rest of the family. The mother-in-law held the 'key' to 'release' her son's wife to independence, whereby the young wife could move into her own house and concentrate on her own family. The 'release'—symbolized by the provision of cooking utensils from the mother-in-law—did not include a release from her contribution to family labor, a factor that could be maintained until the death of the father-in-law who would then distribute his land among his sons (Lukalo, 1973).

According to Caldwell and Caldwell (1987), the limited conjugality in many traditional African marriages protects against a reduction in the desired fertility. Studies have underlined the negative role parents-in-law often play when working against the adoption of family planning methods (see Nagawa, 1994; Caldwell and Caldwell, 1987). Their disapproval is enhanced by their heavy influence among families that maintain a patrilocal dominance of mothers-in-law and fathers.

It is important to note the changes that have occurred in communities with regards to patrilocality and its effect on large family size norms. The high population density today has meant that most sons cannot build their own homes within the homestead, and inter-region migration has become common among the Maragoli and Abanyole in the quest for land to build individual homes (see also Fergusson, 1992). It is expected that this will have long-term implications for reduced parental influence over spouses, and reduce the widely noted notion of "mother-in-laws as barriers" (see Blank 2001).

Other studies reveal that when rural dwellers move to urban settings, they tend to maintain their rural links (Fergusson, 1992). Inter-regional migration of members in Luhyia communities that

are hard pressed for land normally occurs within neighboring regions inhabited by the same Luhyia ethnic group. A pattern of inter-regional migration in such a case would not necessarily present lower family size values as a result of a break from a patrilocal residence for the husband and wife, or imply a nucleation of the family—considering extended family norms are maintained by migrants across the region.

The significance of examining conjugality between husbands and wives in relation to family planning lies in understanding that limited conjugality among traditional communities (some more than others) discourages economic and emotional nucleation and encourages high fertility (Caldwell, 1987). The conjugal units of most rural households in Kenya were still firmly embedded in larger kinship groups until much of the 1980s (Dow et al., 1994: 345). However, socio-economic changes in the country have not left the rural areas untouched. While the residential arrangement for married couples and their families remains patrilocal, the effects of urbanization and interregional migrations resulting are significant when examining increased spousal conjugality. Increased emotional and economic nucleation of the African family is seen as a factor that would enhance a joint spousal experience not only in fertility desires, but communication and decision making regarding family limitation as well.

Fergusson (1992) and Molnos (1973) noted that while polygamy was one of the factors that increased limited emotional conjugality between spouses in the traditional set up, men working in urban areas often maintain “other partners” in their working towns. Money sent home may be sent to the mother in law or to the wife with the expectation that it be shared by the man’s mother and the rest of the family (Nagawa, 1994). Nagawa’s study examining rural women’s support

systems in the absence of their husbands due to migrant labor in Kenya and Swaziland reveals situations of limited financial support from absent husbands—often in the form of school fees and little else—and the significant influence of the husband's family on how money sent by the migrant worker is spent in the home. While economic changes have brought about a general decrease in polygamy, the resulting picture does not necessarily result in increased conjugality between husbands and wives. Instead, women face increasingly unstable social and economic environments in addition to a continued drop in spousal conjugality (see Nagawa, 1994).

The implications these social situations have on fertility regulation, communication, and decision-making vary based on the adopted perspective. Some studies have described the set-up whereby the husband is absent as one which enhances the wife's autonomy in decision making, as is seen in cases of covert family planning that increase in the absence of the husband. According to Frank and McNicoll (1987), an environment in which the husband is absent improves the economic independence of Kenyan women, and boosts their role in the welfare of their family. Frank (1987) further suggests that such a situation enables Kenyan women to truly comprehend the costs of raising children, and increase their sensitivity to the economic burdens they face. While this may not be refuted here, the assumption that increased economic responsibility for women in the rural areas due to husbands working elsewhere leads to a shift from couple involvement to individual fertility regulation and decision making will be examined later under the subtopic on gender.

One question that arises from this type of social situation is how the fertility preferences of husbands who live away from their wives compare to those who live with their spouses. In

comparing contraceptive adoption and discontinuation in rural Kenya, Ferguson's (1992) study reveals higher contraceptive prevalence rates in Ena (a rural town in central Kenya) compared to Kakamega (in Western Kenya). The two towns are differentiated by various socio-economic factors, including land size (bigger in Ena), land use, (cash cropping more common in Ena) and male out-migration (most common in Kakamega). While these factors may have implications for fertility demand, Fergusson's study underlines spousal separation as a strong proximate determinant of fertility—not by increasing contraceptive use for women, but by ensuring seasonality in conception and births. Fergusson concluded that the wives in Kakamega did not necessarily use contraceptives due to the fact that their husbands were away (Fergusson, 1992: 266). In this study, the qualitative data also examined spousal perceptions regarding contraceptive use in the absence of the husband, and secret contraceptive use by wives in an effort to practice effective fertility regulation.

Yet cases in which couples settled on land located away from the husband's family homestead, the resulting differences in fertility communication and decision making has not been specifically examined in the available literature. The perseverance of traditional and cultural adherence, even among families living away from home (in urban areas), has been underlined by some scholars (Ocholla-Ayayo, 1991). However, such literature does not adequately examine the subtle differences between families that live on the husband's father's land, and those that live elsewhere on individually acquired land.

Gender Roles, Fertility Demand and Decision-Making

Demographers have noted the implications of the gendered roles played by husbands and wives within the extended family structure on reproductive health (see Frank and McNicoll, 1987; Caldwell and Caldwell, 1987; Molnos, 1973). In East Africa, reports consistently reveal clearly separate roles played by husbands and wives among agricultural communities in an effort to support large family size desires (World Bank, 1990; Frank and McNicoll, 1987; Molnos, 1973). As Frank and McNicoll (1987) noted, "the major feature of traditional African societies that is characteristically different from others and is well typified in Kenya, is the cleavage of the basic nuclear unit – the man/woman or husband/wife pair and consequent rearrangement of the social and economic functions of the family members" (Frank and McNicoll, 1987: 212).

The main element that underscores the prevailing gendered roles among patriarchal East African communities is the marriage contract. The marriage contract is symbolized by payment of bride-wealth as explained earlier guarantees the husband the rights not only to a couple's children, but to many years of his wife's labor. Studies done among "pre-transition" agricultural communities in East Africa, including the community under study here identified the husband's roles as head of the household, owner or controller of the family wealth, and proprietor of the family's means of subsistence. In the traditional extended family structure, the husband and his family are obligated to clear and prepare land (or make arrangements for its clearing), thus ensuring that bride-price commitments are met. Once this is done, the tilling of that land and the growing of subsistence crops for the family consumption is the wife's responsibility. As a result, while the husband in this family structure is the head, the wife acts as the principal provider for the everyday livelihood of the family (see, Frank and McNicoll, 1987; Molnos, 1973; Lukalo, 1973).

A woman's inability to bear children or the instance of low fertility could lead to divorce, jeopardize the transfer of bride-price to her family, or produce a loss of a livelihood as she loses access to land (see World Bank, 1990; Frank, 1990; Molnos, 1973).

Various literatures attribute these gendered family roles to the earlier lack of male involvement in family planning. According to some scholars, it was logical that men might fail to perceive a problem in having more children because the recurring costs would be essentially invisible—especially if in a polygamous marriage where such concerns lay squarely outside his field of observation (World Bank, 1990:88; Frank, and McNicoll, 1987).

The clear cut division of gender roles in these traditional communities has been related to variations between the reported approval for fertility regulation, and family size preferences. A wife's role of caring for the children and family and provision lends weight to the preference for smaller family sizes—particularly when children are in their infancy or still young (see Boserup, 1989). Various studies have concluded that the male's status as family decision maker has prevented the translation of women's lower fertility preferences into actual or successful contraceptive use (Casterline, Perez and Biddlecom, 1997; Dodoo and Landewijk, 1996; Westoff and Bankole, 1995; Bongaarts and Bruce, 1995; Isiugo-Abanihe, 1994; Ezeh, 1993; Westoff and Ochoa, 1991). However, more recent studies have presented some variations between spousal fertility preferences. In Kenya, studies reveal that the fertility preferences of men and women are more or less similar—questioning the notion of men acting as barriers to fertility regulation (NCPD and Macro International, 1999; 1994).

Yet the question remains: why do couples still fail to regulate their fertility even in cases where they both have low fertility desires? The rote answer has been a lack of communication between husbands and wives that prevents the translation of otherwise positive attitudes towards contraceptive use into effective action. While this opinion is closely examined later in this study, the complexity that arises from the practice of linking structural changes and expected fertility demand to behavior should not be overlooked. Various changes, such as women who have become more involved in earning an income, clearly influence issues of fertility demand (Njogu, 1991; Livingstone, 1989).

The notion of cost-free procreation in African communities has been soundly challenged by the structural changes in the traditional family dynamic as the cost of basic needs like education, health, shelter, and clothing have increased. Frank and McNicoll (1987) explain that the husband's role in present-day Kenyan communities now includes the meeting of major family expenses which have steadily expanded in the period since independence. Amidst the presentation of the woman's near-exclusive role as the main provider of family subsistence and child rearing, the changing economic circumstances that have allowed women to earn their own income from food crop sales and off-farm activities appear to result in an increase in status that allows them more influence regarding issues of contraceptive use (Njogu, 1991; Frank and McNicoll, 1987; Safilios-Rothschild and Mburugu, 1986).

Robinson (1992: 449) refers to Ann–Magrett Jensen's (1989) Western Kenyan Bukusu study, and Safilios-Rothschild and Mburugu's (1986) studies which separately report the positive impact of women's economic development on their status, gender interactions, and attitudes

regarding family planning and decision-making. According to Safilios-Rothschild and Mburugu, “Suggestive signals pointing to potential fertility decline in rural Kenya seem to be associated with women’s access not only to income-generating activities, but even more significantly to ideological changes which allow women to control their income. It is observed that higher contraceptive use in Kenya’s rural areas is in areas where women are generating and controlling their income which, when used to hire labor, serves to decrease the need to use children for labor” (Safilios-Rothschild and Mburugu, 1986).

Frank and McNicoll, writing in 1987, dismissed the likelihood of men’s involvement in family planning. According to them, even the socio-economic changes taking place at the time would not be enough to change men’s overwhelmingly pro-natal cultural attachments. While acknowledging the significance of increased education expenses and the perceptions of the value of education for social and economic mobility as an important factor for an increase in men’s desire for family planning and fertility regulation, Frank and McNicoll underline the fact that this strategy is employed in various ways—some of which would not necessarily lead to a perceived need for family size limitation. Incidences of older children providing income to cover the costs of younger ones, and situations in which fathers do not feel an obligation to educate all their children are common in the country.

Frank and McNicoll (1987) believe that the socio-economic changes occurring in Kenya in the 80s—including growth in the educated population, diminishing land resource, the potential for women to disaffect from husbands contractual claims after they become heads of the household through death, divorce or abandonment, or even male migration—would not necessarily modify

the social structure of family formation or bring about low family size desires. They argue that these developments would enhance the degree of detachment between women and their husbands. The authors present a justification for the government's neglect of male inclusion in provisions for family planning services. They state that husbands and wives are unlikely to have similar interests regarding family planning, and that it is the women who are more prone to change their fertility preferences to lower family size, thus fertility decline falls largely in the realm of a woman's decision to use or forgo contraceptives.

While the significance of widespread evidence from various studies (APPRC, 1999; Fapohunda, 1998; Blanc, 1996; Mburugu, 1994; Njogu, 1991) regarding women's elevated social and economic status in increasing fertility regulation in communities is indisputable, Frank and McNicoll's (1987) assumption that men would always be opposed to involvement because they are more inclined towards pro-natal cultural institutions is contradicted today by various studies that have revealed almost identical family preferences between husbands and wives (Fapohunda and Rutenberg, 1999; Dodoo, 1998; Ngom, 1997; Chikamata, 1996; Becker, 1996; Dow et al., 1994). Despite Frank and McNicoll's (1987) suggestion that detachment has occurred between husbands and wives in regard to lineage issues, the socio-economic changes mentioned above that have developed in Kenya have, in many cases, not resulted in said detachment.

Mothers do not necessarily gain social and economic autonomy when husbands are involved in migrant work. The women in the Nagawa (1994) study reported that they had little say on family size or decision-making—at least 69% had not discussed the issue with their husbands, and among those who had discussed it, the husband's view tended to prevail. Of those who wanted

fewer children than their husbands, all of them agreed to have the higher number desired by their spouses. Even the teachers in the sample, who had an education and an independent salary, did not have the power to decide on the number of children they would bear. Studies continue to reveal wives who do not use, or discontinue use of contraceptives in direct response to their husband's disapproval (Yinger, 1998; Phillips et al., 1997; Dodoo, 1998; Dodoo, et al., 1997; Ezeh, 1993).

While this study does not intend to present the perception that husbands and wives have similar fertility regulation intentions—despite the fact that similar attitudes are sometimes recorded—it does examine how spouses who do share compatible family planning intentions still fail to seek for or practice effective fertility regulation behavior. In the scenario of increased fertility despite the absence of the husband due to migrant labor, how do husbands continue to exercise their dominance in the area of reproductive health even in their absence? How can wives enhance their own dominance—not only economically and socially, but also where fertility control and reproductive health are concerned? What other social, institutional, and cultural factors come into play?

The evidence of secret contraceptive use among considerable numbers of women in the Kenyan communities (Fapohunda and Rutenberg, 1999) seems to provide justification of Frank and McNicoll's (1987) prediction of women exerting their autonomy when making fertility control decisions. This would only apply to women who do so successfully, despite the potential discord expected from their husbands. The qualitative findings in this study address the factors that come into play regarding the success and continuation of secret contraceptive use, as well as women's

perceptions regarding such covert practice in relation to the husband's involvement as a partner in fertility regulation.

Robinson (1992) refers to the NCPD (1988) study of "Male motivation factors affecting family planning" which was conducted in response to increasing criticism that the programs in Kenya were oriented towards women—essentially ignoring men's views. The study found that while Kenyan men still expressed many traditional, pro-fertility attitudes at the time, they also expressed little opposition to contraception in general, and a keen awareness of the rising costs of raising children. Robinson (in reference to the NCPD study) noted that, "the main conclusion which emerged from the Male Motivation Survey is one of inconsistency and contradiction among various attitudes of men. They express pro-fertility values, but are worried about economic considerations. In short the study shows traditional values under attack by modern economic considerations," Robinson (1992: 450).

While the positive attitudes and decreased family size desires of Kenyan men have been acknowledged in various studies—with economic reasons cited as the main influencing factor—this study underscores the way the traditional values work to maintain gender imbalances between husbands and wives. As far as gender relations are concerned, while studies have revealed socio-economic reasons for men to develop positive attitudes towards family planning, an in-depth look at the reasoning behind their involvement—or lack of it—is necessary in order to fully comprehend how subjective elements like spousal communication and decision-making translate into the practical application of fertility regulation. The case for a focus on involving men in family planning in Kenya remains a strong one in some quarters, drawing justification

from the fact that Kenyan men have been regarded as key decision-makers regarding family planning. Whether the husbands are actually involved or not, studies reveal that wives point to their husbands' attitudes and preferences (as assumed by the wife) as having great significance on their intentions and decisions.

Land Holdings and Fertility Demand

Explaining the influence of land holding on fertility falls within the framework of providing social and economic explanations for fertility in third world settings (Clay and Johnson, 1992: 491). Studies that have related land holding to fertility in sub-Saharan Africa and East Africa in particular include Robinson, 1992; Clay and Vander Haar, 1993; Frank and McNicoll, 1987; Caldwell, 1987; Boserup, 1985; and Molnos, 1973.

The community under study here typifies the conditions cited by various hypotheses that link land holdings to fertility demand and behavior. The treatment of linking land to fertility is examined in the largely demographic literature reviewed, noting how various changes are hypothesized to relate to fertility behavior. The contradictions are underlined, and the emphasis of the current study is on the complexity of fertility demand and the inadequacies of simplistic linkage to specific socio-economic factors such as land resources.

As noted earlier, the traditional land tenure system among East African agricultural communities—including the Luhyia community—hinged on lineage land ownership. Land was the single most significant community resource supporting the local economy in terms of the provision of food for subsistence and surplus for sale to acquire other cash related products and

services. Proponents of a definite connection between land and fertility argue that the abundance of available land, its significance to the family economy, and its free-holding within the clan ownership all provided considerable motivation for agricultural communities to support and promote high fertility. More wives and children meant the ability to farm and occupy larger pieces of land—enhancing a family's social and economic status. This is the scenario that scholars like Caldwell and others have used to explain high fertility demand in African communities (see Clay and Vander Haar, 1993; Boserup, 1989). An abundance of land translated as increased motivation for polygamous relationships and large families.

This hypothesis further predicted that enhanced population density and an individualized land tenure system that allowed for individual land holding as opposed to clan ownership would work well for the down turn of fertility among agricultural communities in East Africa and sub-Saharan Africa (Boserup, 1989; 1985; Frank and McNicoll, 1987; Caldwell and Caldwell, 1987). The increase in population density, reduced land ownership for communities, and the advent of individual land property ownership are thus processes that have continued to take place in parts of Africa, specifically in the agricultural communities in Kenya (such as in the study area), and were expected to influence fertility demands (Boserup, 1989; 1985).

Limited land availability led to the out-migration of many male family members (Clay and Vander Haar, 1993; Ferguson, 1992; Goody, 1989; Livingstone, 1989; Boserup, 1989; 1985). Apart from a reduction in the need for children due to a reduced land resource, the high population density and subsequent out-migration are seen to have had further implications for fertility because of an increased marriage age due to out-migration and education, and the

influence of small family size values flowing from the cities (Oppong, 1983 in Njogu, 1991; Goody, 1989).

While the above hypotheses relate decreased land availability to a reduced fertility demand, this relationship has not been established beyond doubt. Empirical evidence has revealed inconsistencies in the causal direction of the association between the amount of land couples own or operate, and the number of children they have (Clay and Johnson, 1992: 491). The land-labor supply hypothesis is supported by studies in Egypt, Iran, the Philippines, and Thailand, where larger land holdings were found to consistently result in larger families. However, evidence from Bangladesh and Zaire raises questions about this kind of simplified causality, citing that a high provision of labor translates only into the need for larger operational holdings (Clay and Johnson, 1992). The hypothesis relating land availability to increased labor demand and thus high fertility is clearly based on communities with an abundant supply of arable land. However, for communities with limited land supply and an increased population density that results in labor that is unable to be absorbed into the land economy, the inapplicability of the hypothesis becomes clear.

Other studies reliant on contradictory empirical evidence suggest the possibility of a totally opposite relationship—increased fertility demand due to unavailability of arable land. The importance of social security for parents in small land-owning communities has been said to lead to various strategies—including large family sizes—to help ensure old age sustenance in the absence of the land asset (Clay and Johnson, 1993). Looking at Kenya, the relationship between land and fertility varies depending on the communities examined. Reduced fertility in the

country has been pioneered by the Central part of the country where land—while reduced in availability—has seen the success of cash-crop farming and enhanced socio-economic development attributed to its proximity to the capital city of Nairobi.

Western Province, however, is situated away from the city and has a population mainly involved in subsistence farming, with some of the highest population densities in the region (Munroe, et al., 1969). The area inhabited by the *Logoli* (a part of the Luhyia ethnic group found in Western Kenya) forms a part of the current study. The high population density has had an impact on various socio-cultural and economic aspects. The sub-division of family land into holdings too small for profitable cash cropping has had a negative effect on the patriarchal practice of land inheritance, and increased the incidence of out-migration—both factors that have been associated with reduced fertility (Clay and Vander Haar 1993; Clay and Johnson, 1992; Fergusson, 1992).

There is no empirical evidence, however, linking land ownership or the lack of it to a decline in fertility. Unlike the Central and Eastern provinces of Kenya, Western Province is considered to be a latecomer to the fertility decline transition that began in Kenya in the late 80s. The area has boasted the highest population density in the country since as early as pre-1960, and while land scarcity may provide a suggestion of potential decline in fertility demand, there is no clear indication as to how long the process might take. Other socio-economic factors like extent of poverty, opportunities for involvement in a non-agricultural economy, and the social cost and availability of contraceptives play a role in translating the social and economic implications of land scarcity into a marked decline in fertility demand and subsequent fertility regulation.

On the other hand, studies have noted a reduced fertility demand in the area underlined by increased unmet need since the 1980s (NCPD and Macro International, 1999; 1994). Although an increase in unmet need tends to suggest reduced fertility demand, the fact that unmet need was registered in almost all parts of the country—with other areas less effected by land scarcity displaying an even earlier instance of unmet need—also implies that apart from land scarcity, other socio economic, cultural, and accessibility factors must be considered before the dynamics of fertility demand can be fully understood.

Apart from the size of land holdings, the land tenure system is also an important factor for exploring fertility demand. Independence prompted the shift of land ownership from lineage possession, to individual owners. The theory behind this change of land tenure from communal to individual was founded on the argument that ownership—especially if individualized—would be secure against state intervention and provide a foundation for economic initiative with individual owners expected to embrace "modern" production methods, techniques, and practices. In relation to fertility, individual land ownership practicing modern, capital intensive (instead of labor intensive) technologies was predicted to have a diminishing influence on overall fertility demand (Robinson, 1992).

Demographers at the time frequently related the policies of the individual land tenure system adopted by the government to small family size values and fertility decline. Robinson (1992) refers to land and education as two of the most positive key policies pursued by the government of Kenya since independence regarding changes in fertility regulation attitudes. Proponents of this hypothesis explain that the individual land ownership further internalizes the economic costs

and benefits of many family activities, as well as decisions on family size within the co-resident family unit (Robinson, 1992: 456). Robinson notes that this theory had already been proven elsewhere, with land redistribution programs frequently resulting in fertility declines (Reining, Priscilla et al., in Robinson, 1992: 426). Robinson relates the decline of fertility and increased contraceptive use in the 1990s to government policies in land and education, with the latter having created demand while undermining cultural structures and traditional pro-natal practices.

The Okoth-Ogendo (1986) investigation of the tenure reform in Kenya and its impact on the economic, political, and social organization of rural society revealed evidence of continued traditional values linked to land—even amidst the widespread tenure reform. An examination of farmer decision making, for example, presented that their perceptions of the nature of land rights and the power derived from them did not significantly change due to an official change to individual land ownership. Land was still regarded as a "family investment" that could not be disposed of except perhaps in exceptional circumstances. Non-registered proprietors also expressed the expectation that land would be governed by the same principles of control, allocation, and use as before the tenure reform. This perception was based on the fact that since registered proprietors themselves had received the land more often by inheritance or family partition than by purchase or gift, they had no moral right to exclude other members of the family from it.

What this reveals about fertility demand and regulation is that pro-natal values of traditional communities continue to have significant influence even in the face of considerable modernization. However, in the specific area under study, given the saturation of land family

divisions, an increase in land purchase may indeed prompt the development of small family size values. Above all apparent connection, the conflict between traditional attitudes and economic changes remain vital aspects for demographic research (Boserup, 1985). Fergusson's (1992) study on contraceptive adoption and discontinuation in rural Kenya noted that the very high population density in Western Kenya has meant that the community can only engage in subsistence economy due to limited land availability. Coupled with low opportunities for income generation, this environment creates a unique scenario from one in which parents use hired labor on larger pieces of land for cash cropping, and send their children to school.

The theories linking reduced land availability to a reduction in fertility remain generally undermined by the existing empirical data. Safilios-Rothschild and Mburugu (1986) noted that "in some areas of Kenya where the land carrying capacity has been exhausted due to population pressure and land overuse, birth rates continue to be high even in the absence of out-migration to other areas." The need for a search for viable explanations for high fertility in Africa despite evidence of significant socio-economic developments having influenced fertility decline in the Western countries is highlighted (Mburugu, 1994).Instead of looking exclusively at land issues, this study examines how spouses relate the existing land concerns and socio-economic and cultural environment to their involvement in family planning practices.

Family Contributions of Children

The other socio-economic factor that plays a part in explaining fertility demand in sub-Saharan Africa is the concept of the family contributions of children. Caldwell's "wealth flows" theory suggests that high fertility demand results when the costs of children incurred by parents is low,

yet yields high returns from the children's labor when the child is still young, or via increased old age security from children who are grown (Clay and Vander Haar, 1993; Caldwell, 1987).

According to the concept of wealth flows, children's life long input in terms of labor and responsibility to parents in old age ensures that the flow of wealth from the younger to the older generation exceeds the reverse flow. The wealth flows theory explains that in third world countries, children are indeed beneficial to parents and therefore parents choose to have large family sizes for long-term benefits (Caldwell, and Caldwell, 1987; Clay and Vander Haar, 1993: 67). Fertility decline in these circumstances is only expected when parents start seeing their children as a socio-economic liability, rather than as contributors to household earnings and welfare. The wealth flows theory has, however, been riddled by contradictions in its empirical evidence, and thus remains largely unproven (Greenhlagh, 1995).

Given the effect on the flow of wealth prompted by the socio-economic changes that have taken place, children's education has been used to explain the resulting social and cultural dynamics. Increased school attendance results in the absence of a child's labor—a change that is expected to have major effects on the flow of family wealth. Education costs coupled with low labor inputs were expected to reduce children's value as increased general costs created room for low fertility aspirations (Caldwell, 1987; Robinson, 1992). Education is also estimated to open up new avenues (by way of employment) for economic independence for both young men and women, thereby releasing them from required adherence to patriarchal structures and demands for high fertility (Bongaarts, 1993: 437).

According to Caldwell's wealth flows theory, as long as parents do not invest much money in their children in terms of school fees and return profit from their labor contributions, the direction of wealth flows from children to parents—resulting in a negative impact on fertility regulation. On the other hand, when children require an investment from parents in terms of educational fees, and the parents also need to hire labor instead of relying on their children, the aspirations for their children's education are enhanced and families prefer less children in whom to invest because the overall cost is considerable. Caldwell argued that "the costs of educating successive children over a short period of time is, in the presence of an active family planning programme, the most significant element in controlling family size" (see Caldwell 1988: 29 in Axinn 1993: 483). Axinn's study among a community in the Himalayas found that children's schooling had a notably positive effect on the parental use of contraceptives, and a strong negative effect on their desire for more children (see Axinn, 1993).

In Kenya, Robinson (1992) noted that increased literacy—particularly women's literacy—had a direct relevance on the successfulness of fertility control programs in Kenya. Robinson attributes the significance of education on fertility control to the value that parents place on education, the widespread educational infrastructure created by the government, and a fee-based cost-sharing approach that ensured that parents were acutely aware of the financial responsibility that their children posed. According to Robinson (1992:456) "two better demand-creating policies would be hard to imagine. The fact that fertility impact was not intentional would not seem to matter to the outcome."

However, while the wealth flows theory relates children's schooling to reduced fertility demand, other studies (see Clay and Vander Haar, 1993) reveal that parents may regard both educated and non-educated children as equally valuable. Differences in this case would only relate to the nature of support received from them—the implication being that the influence of a child's education on positive fertility regulation attitudes in parents would be minimal. Despite acknowledging the significance of education, parents may choose to limit the access to education for various children, creating a spectrum of support to be provided later. Such a spectrum might include staying at the family home with old parents, and expecting girls to earn bride-wealth when they get married. In this scenario, education is viewed as valuable, but not necessary—further complicating the application of the wealth flows theory in African communities.

Clay and Vander Haar (1993) in their study of a densely populated community in Rwanda found that while education varied in relation to the support children provided for their parents, it did not necessarily have an effect on whether the children would support their parents in old age. What changes with education is the type of support provided. As a result, reduced land and out-migration, or even reduced income may not necessarily imply a reduced motivation for fertility demand (Fergusson, 1992; Mburugu, 1994). However, "it is the successful rearing of more children that most clearly defines the amount of support that parents receive, regardless of their ages" (Clay and Vander Haar 1993: 76).

Studies of education in East Africa and Kenya in particular showed the significance of an education for children as a means of social mobility among parents. With limited land availability, investment in children's education is perceived to benefit both the children and the

parents in old age (Mburugu, 1994; Caldwell, 1987; Houghton, 1977). The educational costs and the high value placed on a child's education appear to positively impact the parents' perceptions of family planning—particularly the husband's (Oyosi, 1997; Mburugu, 1994; Robinson, 1992; Kekovole, 1992; Knodel & Wongsith, 1991). Education has therefore become increasingly regarded as an appropriate investment of scarce family resources (Mueller, 1984). A man's success in terms of how many children he has sent through university or secondary school has become a common indicator of male success in this rural area, rather than a focus on how many children a man has produced.

Apart from the presence of high aspirations for children in regards to their education, there is evidence to suggest that there is a marked concern among parents about their children's ability to provide old age security. While important, this is a factor that—according to the wealth flows theory—would not result in lower family size values. Fergusson (1992) notes that in Western Kisa, the continued subdivision of land combined with high population pressure has left a subsistence economy, "largely devoid of opportunities for income generation other than the seasonal sale of surplus food." Small businesses are thus less prevalent and "remittances from urban migrants are the most important sources of cash" (Fergusson, 1992: 258).

Caldwell and Caldwell (1987) explains that the value of children seems to have shifted from labor on land, to old age security—especially in the face of deteriorating economic conditions with parents having either none or very limited economic resources to support themselves in old age. While this theory has been supported by some studies (Clay and Vander Haar 1993: 70), it has not been consistently proven by empirical evidence. Dow et al.'s (1994) study set out to

examine empirical evidence over different periods of time in relation to the theory. Comparing data from their 1981 study in Kenya with their 1993 study, they found that despite the reduction in fertility over that period of time, there had been no significant corresponding modification in wealth flow and nucleation patterns. The study found that the proportions of respondents expecting to receive regular financial and labor assistance from their children increased by 7 and 6 percentage points, respectively, between 1981 and 1992, while a decline occurred in the expectation of future housing assistance.

Furthermore, wives expectations for future support seemed greater than those held by their spouses. The proportion of people expecting regular financial and labor assistance in the future was increasing at a time when economic opportunities were contracting, and in a climate of fertility decline. Further still, approval of family planning did not seem to relate negatively to these expectations of future support on behalf of their children. Men expecting the greatest degree of future support from their children also approved of their wives' use of family planning to delay another pregnancy (78%), and to cease production (63%), while they were themselves, willing to use family planning for the same purposes of delay (51%), and of ceasing reproduction (45%). Similar trends were also reported by their wives (see Dow et al., 1994: 353).

It is clear from studies such as the one by Dow examined above that while fertility demand has indeed been on the decline in Kenya, coupled with actual lower fertility rates (see NCPD and Macro International, 1999, 1994), parents that are adopting family planning may continue to view children in terms of wealth or future support—a factor that was overlooked by the wealth flows theory. Watkins (2000) makes note of similar contradictions in terms of expected cultural

changes in the event of fertility decline in Nyanza—a province neighboring the community under study here. She notes that while practices considered to be "cultural barriers" to fertility change were in place in the 1970s and 1980s during periods of very high fertility, these practices—communal land holding, a highly stratified gender system, and ethnic competition—remain present in Kenya despite the fact that the 1989 KDHS revealed fertility decline in Nyanza as well as nationally (Watkins (2000: 726).

In explaining the seemingly contradictory socio-economic situations in relation to fertility regulation in Nyanza, Watkins (2000) refers to historical evidence that refutes the notion of abundance presented by older men to demographers. This impression of abundance forms the basis of the wealth flows theory, which holds that children equal wealth when there is an abundance of land and other resources that make use of children's labor. When these resources fade, the suggestion is that children have decreased economic value and become a liability—prompting smaller family size values. According to the historical evidence, the perceived abundance of the past that was assumed to have supported high fertility was, indeed, not applicable to the respondents providing such data.

Watkins' (2000) review of survey data from the 1960s revealed changed perceptions of family size as early as the 1960s. Heisel (1968) conducted a survey that interviewed a sample of 744 women of reproductive age living in rural areas dominated by six of the seven largest ethnic groups—including the Luo who also reside in Western Kenya. The survey revealed an increased proportion of women who did not want anymore children. At least 30% among the survey respondents said they wanted no more children, and this percentage increased in relation to the

number of children the women already had. The survey revealed collective uncertainty about large versus small families, with 38% reporting “nothing good at all” about large families, 11% reported “nothing bad”, and the majority of the respondents were unsure. The largest problem perceived to accompany the responsibility of having many children was economic strain (75% of the respondents), (Heisel, 1968: 635 in Watkins, 2000). The question remains, in regard to the family contributions of children, how do husbands and wives—separately or together—relate to the changing nature and timing of children’s usefulness in coining their perceptions of family planning involvement and negotiation?

Re-examining the Role of Norms and Fertility Behavior

The above section reviewed literature that addressed the significance of structural factors including family systems, land abundance, and the family contributions of children when examining issues of fertility demand. Family system structures such as polygamy, patrilineal localities, the influence of extended family enhanced by limited conjugality between spouses, the existing cleavage of gender roles, and gender imbalances are all factors that are reported to support pro-natal values and limit family planning involvement. On the other hand, a reversal of these structures—limited land availability, a decrease in the family contributions of children, monogamy, increased conjugality, and the merging of gender roles has been predicted to reduce fertility demand and enhance family planning involvement.

Two main factors behave as inconsistencies in the efforts of the various studies reviewed above to connect structural factors to fertility regulation. Firstly, the underlying perception of fertility regulation that forms the basis of the blanket linking of structural factors to contraceptive use suggests that the move from traditional to modern is consistently accompanied by fertility reduction. This type of inclusive link is often inconsistent with the actual reality for various communities—especially in sub-Saharan Africa. Secondly, is the non-acknowledgement of the significance of individuals and population groups as agents of fertility regulation behavior as well as various norms and values related to family planning and other political-economic processes. In the following chapter, the linking of structural factors to fertility regulation is re-examined using studies that present the existence of multiple realities as opposed to blanket connections. Said literature underlines the significance of micro-level explanations of fertility behavior, and the significance of understanding of the varied socio-cultural and political economic environments while paying attention to the concept of conscious choice by husbands and wives.

Most of the demographic studies examined above concentrated on positing about urban versus rural populations. While the changes noted are most clear in an urban setting, similar studies among rural or semi-rural populations are needed. While education, income, occupation, and exposure to family planning have been closely related to contraceptive use in urban areas, a more recent question among some demographic anthropologists is how the same changes have influenced fertility regulation in contemporary rural areas (See Greenhalgh, 1995:3).

Lockwood (1995) examines Adeokun's (1983) postpartum abstinence study when exploring the limitations of the employment of culture in demographic structural frameworks. He discusses the perceptions of abstinence behavior and norms, as well as the process of relating postpartum abstinence to its wider setting. He reveals that there is no neat fit between taboo and abstinence, nor between abstinence and lactation despite the assumptions of demographic studies that explain the "culture of abstinence" in relation to fertility controls via norms of lactation and social taboos. Lockwood (1995) notes that Adeokun's study of the Yoruba presents not only differences in the perceptions of what abstinence means between the two communities, but also the presence of varying degrees of abstinence. While cultural structures and values may seem uniform on the surface, in reality they often vary significantly between different groups in one community. Furthermore, individuals provide different meanings to cultural values and this has implications for the employment of various strategies for family planning and reproductive health by different actors. This study seeks to closely examine how married couples interact with prevailing socio-cultural norms and values to create their perceptions of family planning and implement their fertility strategies.

Lockwood further examines the anthropological data presented by Bledsoe et al. (1994) to provide examples of how individual groups within communities are faced with conflicting norms and values (thereby criticizing the notion of a necessarily prescriptive normative structure), as well as some of the strategies employed to resolve said conflicts. Bledsoe et al. (1994) describes the two norms of postpartum abstinence practiced by spouses. Husbands (with the support of older women), seem to prefer the Islamic norm that prescribes social intercourse to resume after forty days, while younger women prefer to practice a form of child spacing—advocating the

resumption of sexual intercourse once the child is able to walk. This varying preference and application is just one indication of the inadequacy of blanket explanations for cultural norms (Lockwood 1995). Lockwood (1995:19) notes the above two micro-level studies demonstrate that norms do not simply determine behavior, but rather may be deployed for particular ends. Lockwood acknowledges the significance of understanding "how, when, and why people use norms to legitimise behavior, or use other notions to escape norms". This study acknowledges that husbands and wives may embrace differing strategies to gain control over reproduction, and that the nature of their approaches would depend on—among other factors—the existing gender relationships in the study area.

Das Gupta's (1997) study provides further evidence from northern India of inaccuracies and gaps in the blanket linking of joint family systems to high fertility as previously related (Davis, 1963; Caldwell, 1987). In a study of a district in Punjab, Das Gupta found high proportions of men who never married, a figure that rose as population pressure increased. Das Gupta attributed the strenuous efforts of the land owning caste to regulate population growth in their households to the fact that they had clearly defined property that subdivided visibly if marriage was not regulated. For agricultural laborers, however, the rate of unmarried men was considerably lower. This was explained as being due to the diffusion of the perception of population pressure among them because they did not own specific productive resources (Das Gupta, 1997: 39). The relevance of Das Gupta's study lies in its ability to emphasize the inadequacies of attributing specific fertility norms to prescribed kinship systems—as practiced in many of the demographic studies both in Asia and sub-Saharan Africa. The evidence provided in Das Gupta's study

reveals subtle differences in fertility regulation values, even among communities that seem to share specific family system orientations.

Bradley's (1995) examination of the relationship between education and contraceptive use among the Luhyia of Western Kenya reveals the presence of considerable complications. She identifies the lack of a clear mechanism that connects education to contraceptive use and fertility decline in the Igunga area of Western Province, noting the possibility of a spurious relationship between the two variables. Bradley's study, like Bledsoe's (1994) analysis of the Gambian culture, exposes higher contraceptive use among older women who have had more children despite the fact that their increased status is less connected to education than local cultural and economic factors like cattle ownership, trade involvement, land hiring, and community leadership. Bradley, like Bledsoe et al., concludes that unlike the traditional variables of education and age, empirical data suggests that women of different ages are indeed engaging in family planning for different reasons, and using different routes to realize their fertility regulation interests.

Fricke's 1994 study on vasectomy presents further findings where the variables commonly related to fertility regulation or innovative behavior fail to provide appropriate explanations for the adoption or non-adoption of the innovation. It follows that apart from education, rural or urban residence, and age, an interrelation of other factors come into play when couples are contemplating and discussing contraceptive acceptance and use. Yet in quantitative analysis, there is little explanation for such 'inconsistencies from the norm' (Fricke, 1997: 261). While such deviations from the norm are described as inconsistencies in quantitative studies, Frick shifts the attention to individuals as creative, active participants in their lives—integrating their

culture and values with material conditions to pursue fertility strategies that result in actual behavior.

Schneider and Schneider (1995) contends that unlike Caldwell's cost and value notion of children's social position, joint fertility behavior needs to be viewed as the outcome of exchanging, bargaining, or constraint between spouses. The husband and wife dyad do not automatically generate a single "family utility function" or unified set of "merged wants" (Ben-Porath, 1978:58 in Schneider and Schneider, 1995:183; also see Bradley, 1995 and Bledsoe et al., 1994) for ethnographic examples. This study supports the notion that individuals and groups have differing reasons and interests for fertility regulation, with implications for the interpretation and use of contraceptive methods. Bledsoe and Hill's (1998) study reveals significant diversity among men's attitudes and responses to the contraceptive use of their wives, and further diversities among women regarding the same issues. "Throughout sub-Saharan Africa, men have a longstanding reputation as obstructing women's use of family planning. Yet the men in our surveys were hardly uniform on this question. Some men expressed moral outrage at the notion of family planning; and stormy arguments can arise when a husband discovers his wife's secret cache of tablets or hears from an indignant older female relative that his wife was seen in the family planning clinic. Other men were not only enthusiastic backers of their wives' contraceptive use, they saw themselves as 'spacing' births by agreeing to abstinence" (Bledsoe and Hill, 1998:24).

Townsend (1997: 110) confirms that to consider fertility as a social relationship distributed between people is to see it not as fixed and unproblematic, but subject to negotiation and

renegotiation between people. Negotiation, far from necessarily resulting in contraceptive use resolution, presents conflict and conflict resolution between husbands and wives who present varying adherences to different norms (see also Goldscheider, 1995; Blank, 1996; Fapohunda and Rutenberg, 1999). The Bledsoe et al., (1994) study shows how, when presented with multiple norms, spouses tended to maintain conflicting perceptions and preferences. These avenues for reproductive conflict often open between husbands and wives who have been conventionally described as adhering to the same norms and cultural values (see Caldwell and Caldwell, 1987).

While economic costs may reduce demand for children among males, issues surrounding family planning and contraceptive use present other gender-related dynamics that the man must come to terms with. Partnership in reproduction has gender implications that (despite the economic reasoning) may not auger well with the man who is traditionally in the dominant position in the relationship. The literature reviewed below notes how the concept of couple communication has been dealt with in various studies while exposing the gaps that appear to be present. The review ends by highlighting the need for further examination of the couple communication process.

Significance of Communication for Contraceptive Use among Married Couples

The literature on family planning communication varies. Some focuses on mass media communication—usually a component of Information, Education, and Communication family planning programs (Omwanda, 1996: Bruce, 1993). Others explore social interaction and communication at the individual level, mainly between women and their peers (Watkins, 2000;

Rutenberg and Watkins, 1997; Bongaarts and Watkins, 1996) and more recently between spouses (see Becker, 1996 for a review; Blanc, 2001; 1996; Muia, et al., 1999; Becker, 1997; Greene and Biddlecom, 1997; Odhiambo-Omondi, 1997; Ezeh, 1993).

Mass media communication prompts both structural and behavioral changes in contemporary developing countries due to the heavy influence of global mass media systems, massive technological diffusions, and trans-national situations. As a result, fertility decline in parts of sub-Saharan Africa like Kenya and Zimbabwe seems to have occurred prior to economic development—suggesting the heavy influence of family planning campaigns, imported reproductive techniques, and international awareness of the population problem (Omwanda, 1996). Many of the family planning programs in developing countries have adopted strategies based on studies of the importance of Information, Education, and Communication in relation to fertility regulation. According to Ferguson (1992), although the harsh realities of the structural adjustment program in Kenya has undoubtedly provided the most pressing collective impetus to limit family size, improvement in Information, Education, and Communication (IEC) as well as distribution logistics have clearly facilitated the adoption of effective contraception.

Turning to individual communication and specifically spousal family planning communication, the concept has attracted wider attention in the field of demography—especially given the widespread recognition of spousal influence on contraceptive use. Various studies have provided increasing recognition of the considerable power men wield in reproductive decision-making in sub-Saharan Africa (see, Ngom, 1997; Dodoo and van Landewijk, 1996; Bankole, 1995; Isiugo-Abanihe, 1994; Dodoo, 1993; Terefe and Larson, 1993; Ezeh, 1993, 1991; Mbizvo and

Adamchak, 1991). These studies relate the enhanced male influence on family planning decision making to socio-cultural and economic factors like persistent patriarchal gender roles that posit the husband as household head and family decision-maker, and the notion that responsibility for the enhancement of the lineage or family name falls to the man.

The reasoning behind the emphasis on examining spousal communication lies in the significant potential of such fertility communication in the actual realization of contraceptive use—especially in cases (noted to be the majority) where spouses have similar low fertility aspirations. Wolff et al.'s (2000:130) survey data examining couple negotiation and the unmet need for contraception in Uganda suggests that, "…lack of discussion however imperfect or one-sided, may pose a significant barrier to a couple's joint decision to cease having children, and especially to women in this setting."

Various studies have provided evidence regarding the significance of spousal communication for the realization of contraceptive use. Lasee and Becker (1997), Odhiambo-Omondi (1997), Salway (1994) and others reveal a positive association between spousal communication and contraceptive use. Odhiambo-Omondi's 1997 study in Kenya suggested that spousal disagreement regarding contraceptive use might be related more to a lack of effective communication than to actual conflicting desires. Fapohunda and Rutenberg's (1999) focus group discussion study among West African couples also observed a positive relationship between spousal discussion and contraceptive use.

The analysis of the 1989 Kenya DHS data reported that, “One spouse’s perception of the other spouse’s approval is more likely to be correct if they have discussed family planning than if they have not, and this relationship significantly affects contraceptive use” (Lasee and Becker, 1997: 15). Using data from the 1989 Kenya DHS, Lasee and Becker’s (1997) study on husband-wife Family Planning Communication and Contraceptive Use reveals that, “95% of spouses who correctly predicted their spouses’ approval of family planning, also reported discussion between partners about family planning, while in the case of women who did not know that their husbands approved, only 66% reported having discussed family planning” (Lasee and Becker, 1997: 8).

While these studies do support the significance of family planning communication between partners in regards to contraceptive use, they do not adequately provide a complete picture of the complicated relationship between communication and contraceptive use because they do not discuss factors such as the direction of the relationships—whether contraceptive use enhances discussion or vice versa. They also neglect to provide or explain reports of non use of contraceptives among couples who report participating in active communication.

Explaining Low or Non-Communication

Previous studies of spousal communication discovered low rates of family planning communication between husbands and wives surveyed in Kenya and other parts of Africa. Fapohunda and Rutenberg’s (1999) study using male and female focus group discussions

reported “difficult and rare communication” between married spouses in the Kakamega district of Western Kenya. In other studies conducted in Western and Eastern Africa, three-quarters of West African men reported that they had never discussed family planning with their wives, while less than 40% of East African men said they had never discussed it (Becker, 1996; Ezeh et al., 1996). Lasee and Becker, in their review of couple studies, note the low levels of spousal family planning communication in DHS reports across several African countries: 30% in Cameroon, 25% in Burkina Faso, 66% in Kenya, 22% in Senegal, 19% in Niger, 44% in Tanzania, and 47% in Ghana (Macro International, Individual surveys from various years in Lasee and Becker, 1997: 295).

Various studies provide culture-based explanations for the observed limitations in family planning communication. The existing gendered imbalances at work in a typical spousal relationship, and the separate roles played by husbands and wives within the family are just some of the factors used to explain low levels of spousal fertility communication. Fapohunda and Rutenberg note that, “factors that inhibit use of family planning also hinder discussion about whether or not to use it. These include traditional beliefs, customs and practices such as sex preference, lineage immortality, old age security, polygamy, naming practices (which require that ancestral names be kept alive through children), pressure from extended family (especially grand parents and parents-in-law, and the persistent emphasis on women’s reproductive rather than productive roles” (Fapohunda and Rutenberg, 1999: 73).

Kekovole’s (1997) study on Reproductive Health Communication in Kenya examined communication between spouses regarding five day-to-day issues: religion, children’s education,

future plans, finances, and family planning. They found that the level of communication that a couple engages in regarding day-to-day issues can have a bearing on how comfortable they are discussing more sensitive topics like family planning. The study reports the highest rate of spousal communication for finances, followed by children's education and future plans, with family planning identified as the least discussed issue (by 27% of men, and 34% of women). The authors concluded that the level of apprehension surrounding family planning discussions could be related to beliefs that the discussion is unnecessary, or might arouse suspicion or distrust (Fapohunda and Rutenberg, 1999; Kekovole, et al., 1997:63).

According to Wolff et al.'s (2000) focus group data among Ugandan couples, some pairs discussed childbearing issues, while others did not. Discussions about stopping childbearing—particularly when the wife's opinion was expressed—were thought to occur among educated, urban couples more than among the uneducated and rural. The focus groups also revealed a potentially high social cost for proposing an end to childbearing perceived by both men and women. The non or low occurrence of spousal family planning communication has also been attributed to the previously popular, female-biased family planning programs that served to promote fertility management as a female responsibility—a strategy that resulted in a devaluation of intra-couple communication while cultivating male disinterest or ambivalence (Dodoo, 1998; Greene and Biddlecom, 1997).

The influence of patriarchal values on spousal relations affects not only the husband and wife family roles, but aspects of communication and decision-making on other family matters as well. While the focus here and in the studies referenced above is the link between spousal family

planning communication and contraceptive use, the notion of low or non communication between spouses is important in that it relates to the nature of the communication practiced by study participants, and has implications for the success or failure of actual contraceptive use.

Gender Dynamics and Family Planning Communication

The increased interest in male involvement in reproductive decisions stems from recognition of the considerable power men wield in the reproductive health arena in sub-Saharan Africa. A women's inability to translate reproductive goals into reality amidst well-developed family planning programs in countries such as Kenya support the perception of men as barriers between women and their fertility desires.

Blanc (2001) singles out characteristics such as the type of relationship—marriage, cohabitation, commercial, casual—and the resulting type of communication between partners as influencing the power relations between partners. Other factors affecting the balance of power include family or household characteristics such as co-residence with in-laws, and the nature of the household economy. Lastly, the social, political, and economic characteristics of the community provide a context within which power relations between partners are determined, as well as the extent to which individuals have access to and use related services (see Sen and Balitiwala, 2000 in Blanc, 2001). Studies show that gender-based power inequities contribute to a lack of communication between spouses (Blanc, 2001: 192). Below, I examine specific gender related factors that may

have implications on family planning communication between husbands and wives in the study area.

A patrilineal system prevails within the study area. The payment of bride-wealth that seals the marriage contract symbolizes compensation of the bride's family for future births. Children are recognized as being a part of the husband's or father's lineage, while having only a secondary relation to their mother's lineage. Implications for this kind of marriage include the delegation of specific decision-making power not only to the man, but his family as well. This scenario provides few options for a wife who may have varying fertility preferences, and a desire to broach the subject with her husband. The strong value of children in the patriarchal structure enhances gender-based power imbalances between spouses in terms of family planning communication and decision-making. Women may refrain from expressing their fertility preferences and intentions for fear that it may trigger their husbands to have children with women outside their marriage, or give their spouse a reason for taking another wife.

Fapohunda and Rutenberg's (1999) study of Western Kenya showed that couples may avoid discussing family planning for the reason mentioned above, as well as assuming that their partner is opposed to family planning, and hesitate to discuss it for fear of angering the partner or causing conflict in the relationship (Biddlecom and Fapohunda, 1998; Rutenberg and Watkins, 1997).

Age and education are two factors that have been considered in bringing about change in patriarchal power dynamics. A spouse's age is related to communication in that wives who are

significantly younger than their spouses (and presumably less powerful) are less likely to communicate about family planning (Drennan, 1998). This explanation assumes that the more advanced a woman's age is—even in a patriarchal setup—the more individual status and power they wield within the family and community. As women grow older, the chance to realize their own fertility goals is much higher than for a younger wife (Bradley, 1995; Bledsoe, et al., 1994) because they have, in most cases, fulfilled their reproductive obligations to the husband, his family, and even the community. This study accounts for how the age of the participants effects fertility regulation in a gender-based scenario.

Other studies have found that equality between partners' education levels increases communication (Blanc, 2001). The presence of higher levels of education is frequently linked to increased family planning knowledge and involvement on behalf of both spouses. These studies suggest that a wife's participation in maintaining the household income provides them with more power, and hence increased involvement in family planning decision-making. This explanation is built on the assumption that a wife's participation in the household income via non-family economies is a result of increased education. However, as Bradley noted, while increased education and income may relate to amplified contraceptive use by women, it does not always imply an enhancement in a woman's status (Bradley, 1995).

As mentioned earlier, the gendered division of labor in African society is seen, in addition to communication, to contribute to diversity in spousal cost benefit examination via child bearing (Dodoo, 1998: 231; Lloyd and Blanc, 1995; Fapohunda and Todaro, 1988; Boserup, 1985) The framework of family decision making, however, presents the couple as unified by common

interests—a notion that does not apply in the African family structure. Significant questions remain unanswered. While family planning involvement for economic reasons is bound to attract male participation, what other factors come into play? How do men perceive their involvement against a backdrop of male dominance when concepts like communication and joint decision-making assume an element of collaboration or negotiation—elements that may be alien in a patriarchal environment with limited conjugality? How do the gendered family roles affect men with positive family planning preferences, and how do they seek to get involved?

Women, on the other hand, continue to shoulder most of the responsibility for family welfare in terms of their children's health and the day-to-day provision of food. More women—including uneducated individuals—engage in income generation activities for this purpose. The assumption that men are less affected by large family size is less appropriate today, since both husbands and wives engage in family provision in various ways. This limited equality does not, however, translate into shared family planning preferences. It is expected that an understanding of husbands' family planning strategies—which may differ from those of their wives—would provide a better comprehension of various aspects of family planning communication between husbands and wives including its timing, process, and outcomes. How do the differences in preferences actually impact on spousal family planning communication in terms not only of occurrence, but also nature, process, and results?

Gaps in Relating Spousal Communication to Contraceptive Use

As a result of various studies mentioned above, spousal family planning communication has been described as a tool that will enable couples to reveal their fertility preferences to each other and make use of contraceptives as a result. The misconception that wives seem to have of their husbands' family planning approval is one area that spousal communication is expected to improve.

This study does not dispute the significance of spousal family planning communication for contraceptive use enhancement. The point of contention is the seemingly linear relationship drawn between spousal communication and family planning realization. While various studies have shown results revealing a significant, positive association between communication and contraceptive use (see Lasee and Becker, 1997; Becker, 1996; Ezeh, 1993), the relationship between these two elements is far more complex than the previous studies' treatment of them.

While studies (see NCPD and Macro International, 1999) record a significant increase in the reported communication, the same cannot be said about fertility regulation. I acknowledge that fertility regulation communication does not necessarily lead to contraceptive use, but it is important to note that the lack of spousal communication is repeatedly cited as one of the major factors preventing the realization of shared but unexpressed fertility goals between partners. The flaw in this hypothesis is the assumption that spousal communication would mainly serve to air positive and shared family planning intentions—serving as the missing link between desires and contraceptive action.

Yet Becker (1996:295) notes that misconceptions persisted even in cases where communication was reported to be high. Becker noted that at the time of his study in Kenya, 34% of women married to men who approved of family planning either did not know that their husbands approved, or assumed that they disapproved. Becker continues by adding that 85% of one or both members of these couples reported discussing family planning with their spouses in the past year (1996: 295). Wolff et al.'s (2000) Uganda study agrees that "discussion is no guarantee of knowing a partner's intent. At least 16% of women and 5% of men in the study did not know their partners fertility intentions even though they had discussed them (Wolff, et al., 2000: 128).

Looking at the Kenyan data and specifically the KDHS 1998 data on Western Province, a further complication regarding fertility communication is revealed. While at least 79% of the Western Province women interviewed reported discussing family planning with their husbands at least once or twice and 40.7% claiming to have done so more often, only 21.9% were using a modern method of family planning at the time of the study. The fact that the province sports the highest levels of increased spousal communication alongside the lowest rates of contraceptive use raises further questions.

Understanding spousal communication depends as well on an awareness of the methodologies used in the various studies. A lot of data comes from cross-sectional surveys that make causal inferences impossible. Lasee and Becker (1997) noted that rather than predicting contraceptive use, discussion between spouses about family planning may actually have occurred after contraceptive acceptance—given that the questions discussed referred to the 12-month period. In

the DHS data, the questionnaire measures only the frequency of discussion, without providing information regarding the content of the communications.

Kekovole et al. (1997), also using a questionnaire format, reported that while females were more likely to say they initiated spousal family planning discussions, 89% of men and 80% of women who had discussed family planning reported that the discussions were in support of family planning. A more comprehensive exploration of the content and context of spousal discussions regarding fertility regulation is needed to provide a balanced perception of the effectiveness of communication about family planning.

Linked to the question of methodology is the issue of definition. Some studies have defined communication broadly, others narrowly. Hill et al. (1959) described three dimensions of effective communication: discussion, agreement, and empathy. Adopting the Hill definition, Lasee and Becker (1997) found that the wife's perception of her husband's approval of family planning was the most powerful in explaining contraceptive use in Kenya. Similar findings have been reported in Ghana and Puerto Rica. Although the DHS' use of partners to provide proxy reports may not be entirely valid, the DHS couple file does provide an opportunity to further examine specific couples and compare both individual and partner reports.

Lasee and Becker (1997), in an effort to argue for a broader examination of the definition of communication, note that most of the studies mentioned above defined communication in varied ways and few of them used all three dimensions of effective communication—agreement in approval, discussion between partners, and spousal perception of the partner's approval. Other

studies have gone as far as using discussion as the only measure of communication (Lasee and Becker, 1997:11). This study makes use of qualitative data to provide insight into the circumstances under which communication occurs, as well as issues of timing, content, and manner of communication—all factors that help untangle the complexity of spousal family planning communication and its implications for contraceptive use. The current study also makes use of DHS data to examine all three aspects of communication, as suggested by Lasee and Becker (1997). The use of qualitative data, though not longitudinal in nature, will allow for increased input regarding its definition as well as provide insight into the decision making processes while putting power relations between the couples into perspective.

An interest in investigating communication further has also been embraced by studies on unmet need that use both survey and qualitative data to present an intricate picture of the nature of communication. According to Biddlecom and Fapohunda's (1998) study examining women's covert use of contraceptives, the husband's disapproval of contraception works through spousal communication, rather than as a direct influence on covert use. This raises the same questions regarding the faulty nature of a purely linear relationship between spousal communication and positive contraceptive use. Wolff et al. (2000), using survey and focus group data from the 1995-96 Negotiating Reproductive Outcomes study in Uganda, also question the way the prevalence of the notion of consensus decision-making in much of the demographic research on unmet need serves to simplify a complex situation more than providing reliable insight. They characterize negotiation in four stages—from normative precedent for decision making, to communication, disagreement, and conflict resolution. Their study found that indirect forms of communication tend to predominate, contributing to the tendency of both men and women to overestimate each

other's demand for additional children. The perception of partner opposition also significantly enhances the use of traditional contraceptive methods over modern ones. One of the intentions of this study is to examine communication in a broader and deeper sense, taking the surrounding dynamics into perspective to unearth a more reliable understanding of the connections between spousal communication and contraceptive use or non-use.

Summary

This chapter began by underlining the need to further examine the complexities of fertility demand, specifically regarding spousal regulation behavior. The literature reviewed makes assumptions about the impact of structural influences of fertility behavior, yet remain inconclusive—revealing inadequacies in both socio-economic and cultural explanations of fertility issues.

The anthropologically linked demographic literature reviewed in the second section of the chapter acknowledges the necessity of taking both varied realities and potential variations in interactions with local culture and fertility behavior into consideration when contemplating family planning issues.

In highlighting and underlining the notion of multiple realities and individual agency, the inadequacy of linking structural factors to fertility regulation behavior supported by the reviewed literature has guided this study to note both the existence of unique and varied perceptions of

family planning among groups and individuals. While the traditionally studied structural factors are important, couple studies and family planning programs would benefit from a more comprehensive exploration of spousal fertility regulation. This study intends to build on the current knowledge by developing the notion that spousal family planning communication—while significant for contraceptive use—is varied and complex, with diverse results and implications for contraceptive use. An examination of the spouses' understandings of family planning from their own perspectives is important in that it sheds light on the various realities and processes at the socio-cultural and political economic levels that inform and motivate men and women at different points in their conjoined reproductive history.

CHAPTER THREE

Conceptual Framework

Introduction

This study, while primarily concerned with contraceptive use, specifically focuses on the factors surrounding the perceptions of family planning held by husbands and wives, as well as the way they communicate and make decisions about fertility regulation. Such an examination of family planning requires the treatment of factors surrounding not only the individuals, but other significant members of their families such as spouses and members of their social networks, addressing practical dynamics such as the social elements that surround the adoption of contraceptive use.

Conceptually speaking, family planning exists in varying notions both within and across multiple levels of society, including the national, local, and spousal realms. This study problematizes the assumption that individuals, husbands, wives, local communities, and family planning programs share a unified set of desires or intentions regarding fertility regulation that they either approve of or disapprove of. Instead, this study introduces the view that there are varying perceptions of family planning being exercised in relation to the prevailing socio-economic and cultural contexts.

This study borrows from anthropological studies to employ a framework that while acknowledging various perceptions of family planning in society, places emphasis on individual

agency both in creating perceptions and intentions and in developing avenues for spousal communication and its outcomes.

A Culture and Political Economy of Fertility and its Application

As noted earlier, the quest for a widely accepted conceptual framework for reproductive behavior that is broad enough in scope has not been exclusive among mainstream demographers. Recent work by anthropologists and sociologists also seeks to provide a new perspective on fertility transition.

One such perspective seeks to explain fertility transition by cross-cutting disciplinary boundaries in a bid to provide a more balanced and broader understanding of reproductive behavior. Greenhalgh (1990) refers to this as the political economy of fertility, because it draws key insights and methodologies from research in political economy. Greenhalgh's (1990) perspective on fertility depends on a contemporary understanding of culture and its implications for examining and understanding demographic behavior. The approach further recognizes the centrality of examining culture in reproductive research which Greenhalgh (1995) refers to as a "culture and political economy of fertility" in recognition of the special role of culture in shaping reproductive outcomes (Greenhalgh, 1995: 14). Said perspective includes aspects of cultural applications which are relevant for demography as presented by various authors, including (Fricke, 1997; Kertzer and Fricke 1997; Hammel, 1990).

A culture and political economy of fertility theory directs attention to the embedded community institutions in structures and processes operating at regional, national, and global levels, as well as to the historical connections between those macro-micro linkages. A political economic demographer begins with an understanding of the historically developed global forces—the world market, the international state system—which shape local demographic regimes. They follow by identifying the ways these forces impinge on regional, national, and local institutional environments and trace their effects on individual and couple fertility behavior (Greenhalgh 1990; 1995).

As Greenhalgh (1995) pointed out, the culture and political economy approach is based on a set of assumptions that differ from the traditional theories of demographic transition. It assumes that there is not one demographic transition, but many kinds of reproductive institutions and outcomes in both high and low fertility societies. It assumes that demographic dynamics are culturally specific. It assumes that low fertility may not always be the required end point of demographic history, depending on the culture and political economy in which reproduction is embedded. Lastly, it assumes that low fertility may not necessarily be good universally, but that it is culturally defined and may indeed be group specific within various communities. One of the objectives of this study is to examine spousal understanding of family planning and the processes of their communication and decision-making practices. This objective necessitates going beyond traditional demographic parameters in terms of both theory, and methodology. The task at hand could benefit significantly from culture and political economy perspectives in terms of providing a guiding, general framework.

The concept of agency, as provided in cultural and political economy, guides this study in the understanding that both husbands and wives are not merely acting according to culturally or even economically prescribed norms and expectations. This perspective underlines their agency in constructing their reproductive outcomes while relating to the prevailing socio-cultural economic and political environments. It is expected that such an understanding of fertility behavior will enable us to move away from a reliance on the expectations of demographic behavior, built on a unilinear dependence of economic changes—a perspective that fails to accommodate differences within groups of people who may have undergone similar economic changes.

This study, despite its effort to expand the knowledge base, is limited in its complete application of a perspective that relies heavily on contemporary anthropological reasoning and methodology. It remains rooted within the discipline of Sociology, not only employing a mix of quantitative and qualitative data, but also recognizing and making use of the traditionally used variables—long found significant in explaining fertility behavior. Spouses' age, education, economic status, accessibility of family planning services, residence, and occupations are all variables that are used to examine their fertility regulation behavior. However, the use of both quantitative and qualitative data enables the application of the conceptual framework in the design and analysis of the research surrounding the specific objectives.

Key Attributes of the Culture and Political Economic Framework

The key attributes of Greenhalgh's framework include Level, Time, Process, Causality, and Method (see Greenhalgh, 1990: 94). The Levels refer to different tiers of society—from local, to regional, to national, to global—each of which supports a variety of structures and processes that effect family planning and fertility behavior.

Greenhalgh (1990) notes that the main factor is the interconnectedness of different contributing factors at various levels, with local, national, and international factors all contributing to fertility behavior. A political economy of fertility acts as a multi-leveled field of inquiry that is attentive to political and economic, as well as social and cultural forces (Greenhalgh, 1995:13).

At the couple level, while involvement in the cash economy and limited local employment opportunities often lead to the husband migrating to town or the city for employment, this arrangement may place more responsibility on the wife and provide motivation for contraceptive use. However, husbands staying away from their wives may be more suspicious of the implications of contraceptive use on their wife's potential for extra marital affairs. Thus change in structural factors may impact differently on husbands' and wives' contraceptive use motivations.

In his presentation of a thicker demography, Fricke (1997) acknowledges the significance of a framework of analysis that calls for recognizing and examining various levels of analysis, while

boosting the role of local meaning rather than relying on a causal model that applys to individuals across the board (see Hammel, 1990; Fricke, 1997; Kertzer and Fricke, 1997).

Notions of Family Planning at Multiple Levels

As already noted in this study, there is considerable documentation regarding the high rates of family planning knowledge among Kenyan men and women. Such knowledge, however, is often measured by an awareness of a modern method indicator, and remains a narrow concept with limited usefulness in examining fertility regulation behavior.

According to this study, apart from the program-promoted meaning(s) of family planning (individuals and couples making decisions about controlling the timings and number of their births), various communities also attach popularly held meanings to family planning. An examination of spousal perceptions of fertility regulation recognises that such meanings—related to the local socio-cultural and political environments—are diverse, and that people embrace some meanings more than others when making and justifying contraceptive use decisions.

Global Level Understanding of Family Planning

A global level understanding of family planning is advanced by international advocacy through international population policy (which is advanced by international organizations), academic proponents, international financial institutions, and previous colonial population and economic strategies.

Population regulation programs in Africa and across the developing world have their roots in international population and financial institutions that have—over extended periods of time—engaged in population counting and making comparisons within countries, across regions, and between continents while linking the underdevelopment of Africa to the high fertility rates and populations recorded in the surveys consistently undertaken by such organisations across the region. These organisations—usually sub-groups of the United Nations—are further connected to international financial institutions such as the World Bank and IMF. Their perceptions of economic development are rooted in theories of modernisation and population transition which are tied to financial aid and development assistance that the underdeveloped countries in Africa need (see also, Watkins, 2000).

The perception of family planning practiced by these international organizations focuses on reducing fertility rates in the hopes of reducing population growth. National governments are flooded with a wide range of fertility control products, such as modern contraceptives for women, for the implementation of fertility regulation programs that are expected to modernize the country's economic growth by reducing the overall population. Factors that become important to this analyses include proponents of global level understandings such as government policies linked to international population programs, the process of implementation, the influence of media messages, and the spousal communication processes and contraceptive use intentions. Effort is made in the analysis of the data to examine and identify links to various levels of family planning, both as expressed by participants when and if this happens, and as inferred from the data.

National Level Understanding of Family Planning

A national level understanding of family planning is advanced by international advocacy, government policy, programmatic emphasis, and mass media promotions.

The Kenyan government established the first national family planning program in Africa. The national population policy in Kenya has been influenced by international population organizations which have underlined the need for population control. The family planning program is conducted nationwide, with an emphatic linking of economic development and population control. While the Kenyan government may have officially embraced the connections between reduced fertility rates and economic growth to the point where they have established nationwide structures well into rural communities for implementation of the family planning program, key government leaders and local family planning programs have largely altered the hard and fast population reduction concept to further promote the notion of family planning for the health of the mother and child, as this is a more popular notion among various communities.

Watkins (2000) noted that the notion of reducing fertility rates and population was initially negatively received by local populations who had experienced similar intentions on the behalf of previous colonial masters. In the post independence era, communities with large populations have exercised the majority of the political power, reinforcing the influence of ethnicity on national politics and offering significant opposition to family planning aimed at reducing the overall population. In response to this perception, the development of family planning programs which focus on reduced fertility in the interests of the health of mother and child in guarding

against infant, child, and maternal mortality has been promoted at the local level. Today, these local programs engage in a wide, mass-media campaign depicting the ways that fertility regulation enhances a modern family's health (see Muia et. al., 1999; Odhiambo-Omondi, 1997). Family planning awareness at the national level present as key factors the notions of family enhancement—that a healthy, modern family starts with a responsible father and husband who engage in fertility regulation.

In this study, the various understandings of family planning presented by study participants are further examined, while traces to national level understandings are identified and examined as well to provide insights regarding other related factors or processes that modify or enhance the application of these understandings by various local groups or—more specifically—spousal construction of family planning perceptions.

Secondly, effort is made to provide insights regarding whether and how the national level understandings of family planning and the various processes that put them in place influence individuals and couples in the construction of their own understandings of family planning, their family planning attitudes and intentions for contraceptive use, and the communication and decision making processes between spouses.

Local Level Understanding of Family Planning

A local level understanding of family planning is advanced by the socio-economic and demographic status of the household, local information and services, the availability and

accessibility of local family planning services, and local institutions and values related to family structure, gender roles, and fertility demand.

Watkins' (2000) study examining local and foreign models of reproduction in Nyanza province and Western Kenya uses historical, quantitative, and qualitative evidence in an effort to recognize their contextual significance (such as pre-colonial, colonial, and post colonial socio-economic and political changes) in the formation of local fertility models. It also emphasizes the influence of community fertility perceptions in linking high fertility values to perceived abundance for large families and the restriction of fertility regulation in the context of morality.

According to Watkins (2000), unlike the traditional demographic model where fertility values move from high fertility (traditional) to low fertility (modern), multiple fertility models and resulting choices may exist at the same time in the same community—even amidst a changing socio-economic environment. While economic factors like education and income play a significant role in the fertility choices that individuals make, the social networks remain significant in their ability to uphold the various models—casting doubts and imposing morality pegs regarding decisions and discussions about contraceptive use within the local community.

The historical changes that occurred in Kenya were mirrored by changes in family planning motivation. The pre-colonial and colonial eras were characterized by an indigenous high fertility model that was based on community perceptions that linked high fertility to an abundance of wealth. The colonial and initial post-colonial eras were characterized by the introduction of a low fertility model that was based on community perceptions that linked smaller family sizes to greater economic mobility, coupled with morality pegs on contraceptive use. The late post-

colonial era was characterized by a low fertility model that linked contraceptive use to the small family size already valued by progressive, urban, educated couples.

The current study recognizes the existence of a variety of current family planning models, and that while socio-economic changes are indeed important for fertility preferences, the influence of non-structural factors—including strongly held community perceptions—play important roles in the enhancement of various fertility preferences and family planning intentions for spouses.

Questions that arise in this regard include the following. What are the local social, cultural, and political economic scenarios? What local institutions and practices are related to popular family planning perceptions? How are these related to the national and global level understandings of family planning? What are the locally held family planning notions, and who are the proponents at the local level? Most importantly for this study, how do individuals and couples incorporate or modify popularly held notions of family planning for their own personal comprehension and involvement?

Spousal Family Planning Understanding

Spousal family planning understanding is advanced by the socio-economic and demographic status of the individual in relation to their partner, the interaction of the individual with local level "agents" and perceptions, interaction with socio-economic and cultural environments, perceptions of marriage and gender differences, and the influence of relevant others (partner, parents, parents-in-law).

While this study considers socio-economic factors to be significant, more important is success in connecting spousal fertility motivations and preference formation processes. How husbands and wives form their perceptions regarding family planning and their prospective contraceptive use involvement within their respective realities and among the multiplicity of models available stands at the core of this exploration. This study does not simply set out to acknowledge similarities in contraceptive knowledge or differing preferences between husbands and wives, but seeks to examine spousal motivation, comprehension, and communication regarding family planning issues.

This study examines the KDHS variables on knowledge, attitudes, and contraceptive use intentions and qualitative study data in an effort to reveal the varying levels within what may appear to be reports of similar knowledge or attitudes. The varying levels of knowledge or attitudes and contraceptive use intentions between spouses provide an indication of the potential for contraceptive use, yet such levels of knowledge or attitudes regarding family planning are many times obscured in the widespread positive reports provided in questionnaire design. The varying levels of knowledge, attitudes, and motivations for family planning are further examined for factors such as the influence of social networks and mass media communication.

Local notions of family planning may be based on the changing socio-economic conditions, adapting the cultural values and traditional practices to fit the socio-economic changes. Yet apart from such factors, there are other elements that must be taken into consideration when examining spousal family planning, such as issues of trust (especially between younger couples), the relative status of the wife in the family, the influence of the extended family, a wife's perceived

need for more time outside of the family chores for herself, the influences of social networks, perceptions regarding the implications and side effects of contraceptive use, and secondary infertility issues. All these and others are issues that may have implications that can be embraced or viewed negatively, even when both spouses approve of family planning.

Therefore when it comes to the couple, the focus is not necessarily on the generally held notions, but on how husbands and wives interact with these notions to engage in creating family planning intentions for themselves for adopting specific strategies at various points in their lives.

The Concept of Time

Fertility behavior must also be considered in its historical context. The roots of observed behavior changes or resistant behaviors can be traced and explained within the context of long periods of time. Stamm and Tsui (1986) for example note that while changes in the value that children hold may foster fertility decline, deeply rooted familial values hinder the completion of the fertility transition.

Time as an element of analysis in the political economy of fertility addresses how fertility perceptions and behavior can be attributed to different structures and processes operating at different historical periods such as pre-colonial, colonial, and post independence. In pre-colonial Africa, regional migration and occupation formed a significant part of many communities, and larger numbers meant power in terms of successfully establishing of a community within a certain region. While the establishment of colonization's artificial boundaries and organized governance, as well as Western education and Christian religion are often used to explain the

enhancement of small family values, the political significance of large populations as a means of ethnic power—especially in the post-independence era—served to support the long-held, large family size values (see Kokole, 1994). An historical view provides this study with a better understanding of the roots of various fertility values apart from existing family planning programs and policies.

This study acknowledges and seeks to examine the significance of various political-economic processes linked to previous and current eras, such as the prevailing significance of population numbers in determining ethnic political significance in Kenya today and participants direct or indirect references to these is highlighted in the analyses.

While Greenhalgh's framework examines the concept of time in terms of historical contexts and various processes related to different eras, this study further emphasizes a more varied concept of time. Time is also addressed in relation to marriage and reproductive history, with the expectation that how long a couple has been together will shed light on their family planning goals and practices. Accordingly, reproductive history in this study is examined in terms of initial family size, incomplete family size, near complete or complete family size.

Furthermore, spousal communication about family planning is not presented as a one-time communication that either leads to contraceptive use or non use, but is understood to be a process that varies in time—a process that cannot be simplistically related to expectations dependent only on its occurrence at a specific period of time, as is suggested in most quantitative studies, but may change its forms and results at various times of the couples reproductive history.

The Concept of Process

A political economy of fertility is concerned with processes at all levels, including social, cultural, political, and economic. The link between political and economic forces and processes warrants particular attention in its relation to the dimensions of social and cultural organization (Greenhalgh, 1990: 95). In a comprehensive understanding of spousal fertility regulation behavior, both broad political forces such as international and national organizations or policies, as well as individual issues between husbands and wives such as security in old age, and reproductive control must be taken into consideration.

For example, international population policy and national policy programs use widespread resources to place local family planning units in rural communities to influence the family values of local people. One of the national policies noted in previous studies is the practice of raising the cost of children through the spread of the notion that education is the right of every child—sometimes with penalties for parents when this is not met (see Watkins, 2000). However, family planning and contraceptive use is undertaken by individuals and couples, and the small family values spread at the community level do not necessarily translate into contraceptive use at the individual and couple levels (Greene and Biddlecom, 1997). In addition, couple politics come into play and while contraceptive use in many cases involves either or both spouses, their motivations may differ and their involvement is often based on upholding varying values while also considering implications for gender relationships at the couple level.

Fricke (1997) in his presentation of cultural theory for demography emphasizes the significance of examining culture at different levels, acknowledging "local, culture-specific rationalities, in the building of which actors are important perceiving, interpreting, and constructing agents" (1990:456). In this perspective, it's important to analyze meaning and motivation while adequately evaluating behavioral "divergences from the rule". "As models of reality, cultural patterns constitute the perceived worlds of human actors and define the significance of behaviors and institutions for the analyst" (Fricke, 1997:253). Such an approach therefore underlines the importance of discovering what is significant from the point of view of the actors themselves (see also, Hammel, 1990; Kertzer and Fricke, 1997). This study pays specific attention to political economic processes at the couple level, because they provide the environment in which spouses seek to implement fertility behavior.

The spouses interact with the wider environment and apply individual agency when forming their own preferences, yet the marital set-up may require them to successfully engage with their spouses and—in the process—address various political-economic factors or processes while seeking to advance their reproductive or fertility regulation agendas. The question remains, how do husbands and wives translate the family planning messages that they approve of or do not approve of into their own family planning intentions, taking into consideration their own needs, costs, and benefits? How do husbands and wives interact with local, national, and global notions of family planning in enhancing their own intentions and strategies?

Various factors are expected to play key roles in influencing husbands' and wives' understandings of family planning. These factors include: spousal age, education, and income

differences; reproductive history; marriage history; existing family size; locality of family home; spousal living arrangements; perceptions of contraceptive use on spouse's sexuality; perceptions of spouse's reasons for contraceptive use intentions; and trust factor. The social, cultural, and political-economic process at wider levels include: mass media interaction; adherence to local values regarding children, the family, and gender; and the wider political environment on all levels including extended family involvement to local and national leadership and processes directly or indirectly related to fertility regulation values. The notion of process underlines the significant role of the various actors in shaping desired fertility regulation behavior in their interactions with the socio-cultural political economic environments as upheld by the framework.

The Concept of Causality

Causality in demographic political economy directs analytic attention to structure, agency, macro-environment, and micro-behavior. This analysis focuses on both the broader, historically developed structures and processes that effect people's options, and also examines the motivations and strategies that people either consciously or unconsciously employ to achieve their goals. In this case, people are viewed as actors, and while the macro-environment may help develop structures that define people's options, individuals play a significant role in the realization of their own reproductive goals (see Greenhalgh, 1990; Fricke, 1997; Hammel, 1990).

This concept is applied in the current study by viewing the demographic actors—husbands and wives—as goal-oriented strategizers operating in an environment of opportunities and constraints (see Bartlett, 1980). The focus group analysis examines the reasons behind the various notions of different participants. Male and female participants' presentations of knowledge, attitudes, and

motivations for family planning are analyzed in relation to the influencing factors of existing structures and the role played by the individual. This is referred to as the *individual agency* of husbands and wives as practiced regarding fertility regulation. The focus group data is examined for insights related to individual interaction in wider social, cultural, and political-economic structures and processes that inform the comprehension, communication, and practice of family planning.

The insights we are expected to glean from the focus group data related to individual agency or interaction with social, cultural, political-economic structures include varying interaction with and the upholding of certain familial values (including the value of children), spousal perceptions of gender roles and their actuality, involvement in family provision, perceptions of the impact of family planning or the use of contraceptive methods on both the individual and the couple, perceived confidence in contraceptive use, and the perceived effects of family planning communication and its subsequent nature, timing, and outcomes of communication employed by husbands and wives at varying stages of their marital and reproductive history. Given that both husbands and wives potentially uphold these factors in a varied nature in their interaction with the structural aspects such as land scarcity, move from familial home and source of income, aspiration for children's education, household income earning, wives and husbands' education and ages, influence of social networks, varying understandings of family planning and communication processes are expected from the focus group discussions data.

Examining spousal family planning involvement is expected to reveal a variety of symbolic expressions of the cultural, social, economic, and institutional environments experienced by

individuals and partners. That family planning is indeed negotiated between husbands and wives further lends support to this perspective, examining both the wife and the husband as individual actors whose relationship—though defined by culture—provides an avenue for negotiation that would otherwise be termed as a cultural outcome determined by the marriage practices and their implications for spouses within that community.

While some studies have simplified the scenario by examining either the husbands', or the wives' fertility goals and interests—with the reasoning that the husband's interests prevail anyway—this study addresses the notion that spouses often do not know their partner's fertility desires. Their reproductive outcomes frequently reveal neither of the spouses' actual intentions (see Becker, 1997). Even in cases where the husband is pro-natal, it is imprudent to assume that his interests are consistently served in the couple's reproductive life.

This study appreciates the centrality of gender in spousal decision making, and recognizes that husbands and wives wield assorted authority when protecting their interests—drawing on this in the negotiation processes. It is important to first understand spousal family planning interests and motivations, and secondly, to examine the negotiation processes that occurs between them to produce fertility outcomes. A complete expression of partnership between spouses inevitably requires or implies that the male partner must relinquish the dominant position. Various scholars have identified this ironic expectation as the major stumbling block for the enhancement of partnership in general, and of reproductive health partnership in particular (see Greene and Biddlecom, 1997). That fact that men are not likely to trade their dominance for the purposes of partnership without clear indications of the expected benefits is an issue of significant

importance in the field of family planning and reproductive health. In analyzing the negotiation process, this study further examines the implications of the various negotiation strategies employed and how the subjective reality experienced by either couple informs the negotiation intentions, strategies, and outcomes with regard to the potentiality of partnership.

Methodology in the Culture and Political Economic Framework

This study's analytical framework employs both quantitative and qualitative research methods. While the use of quantitative methods was traditional in demography until recently, it does not suffice for the processes employed in political economy. This analytical inquiry requires the further employment of more qualitative methods in conjunction with quantitative ones in order to provide comprehensive insights into the numerical analysis traditionally applied in demographic studies. Bledsoe and Hill (1998), Bradley (1997), and Bledsoe, et al. (1994) are just some of the studies that have made the value of qualitative data clear.

The use of focus group discussions (FGDs) enables this study to use qualitative concepts and provide insights into the cultural and political-economic processes that influence fertility behavior. FGDs allow for the use of more qualitative concepts such as understandings of family planning, couples communication processes, and the collection of data via open-ended questions which prompt participants to provide detailed explanations. As a result, we can learn not just whether participants know about contraceptive methods, but the extent of their technical knowledge as well as their perceptions of this knowledge. The dynamic nature of approval as it is experienced by different participants and the varied implications for its influence on contraceptive use is also revealed by FGDs because they present opportunities for probing the

discussions between participants—revealing factors not previously accounted for in questionnaire designs. The FGDs enabled participants to report not only the occurrence or non-occurrence of spousal family planning communication, but also elaborate on the natures of different communication strategies, their timing, and the outcomes.

While the best way to understand the implications of such processes on contraceptive use would be in a longitudinal study following the various points of spousal family planning communication within a time-frame of their reproductive years, this study deduces its representation from the focus group material provided by various participants at different stages in their reproductive years.

Summary

The conceptual framework provided in this study emphasizes the multiplicity of reality in socio-cultural and political-economic contextual environments, and their influence on fertility regulation outcomes. The framework used in this study specifically underlines the notion of the individual as an active agent, exposing further multiplicity at the individual and couple levels. Multiple realities are actualised in the processes of causality where, for various reasons, individuals seek to uphold certain aspects of values surrounding family planning. This further calls for spousal communication and negotiation as examined in this study.

That the individuals interactions with various social and political-economic processes change over time in their reproductive history is further underlined—noting that fertility goals are constantly changing and not necessarily pre-planned.

The Culture and Political-Economic Framework of Fertility is best suited for use in this study (rather than the conventional demographic approaches used to study contraceptive use) for varied reasons that include:

- The notion of multiplicity provided by the framework enhances the study's examination and understanding of variations in specific elements such as knowledge, attitudes, and intentions for different spouses. Comprehending these elements provides an increased knowledge of how they relate to, or fail to relate to increased contraceptive use at specific times for different couples.

- The concept of levels and processes as understood in the conceptual framework goes a step further than the structural functional approach and other conventional approaches that provide blanket linkages between structural factors and contraceptive use or lack of it—leaving little room to explain any "deviations from the norm" or unexpected behaviors. The conceptual framework enables advanced couple level examination while appreciating the variation of individual spouses' interaction with structural factors at various contextual levels and the implication for contraceptive use motivations.

- The concept of time in the political-economic framework calls for an examination of contraceptive use and various influencing factors within the context of time in relation to

the individual and their spouse. The concept of time provides better insight into what may be seen as discrepancies in conventional analyses.

- The political economic framework combined with the notion of individual agency provides an appreciation of the potential differences between husbands and wives in terms of fertility goals, motivations, and strategies. While a conventional structural functional approach expects husbands and wives to work towards common family goals, the political economic framework recognizes the presence of subtle differences and sheds light on what may seem like irrational decisions.

The framework provides insights into what is otherwise termed as discrepancies between spouses' family planning communication and expected contraceptive use. This enhances this study's examination of couple family planning communication and insights regarding the communication process that would not be obvious in the application of conventional demographic or structural functionalist approaches.

Furthermore, while the reality of male dominance is noted, the political-economic framework emphasizes the need to examine the intentions and practices of both husbands and wives. This allows us to more clearly understand the potential for dominance held by either spouse at varied times, and the resulting implications for success in fertility regulation.

In chapter five, the methodology used to collect and analyze data for the study is presented. The methodology was specifically applicable to the conceptual framework as presented here, allowing the study to re-examine aspects of the framework through the findings later presented in chapters six and seven of this study. Chapter four provides background information on the study area.

CHAPTER FOUR

Study Site and Population Description

Country Profile

Kenya—situated on the East Coast of Africa—is a country that has, over the years, been referred to in relatively positive terms when compared to its war-torn, impoverished neighbors like Somalia, Ethiopia, Uganda, and Tanzania. Kenya is the only country in the region that has not gone through a massive, post-independence civil war. Poor governance and corruption have been identified as the most significant factors responsible for its poor economy. Despite a declined economy, however, Kenya has experienced some specific development-related achievements that have placed it ahead of several other countries across the continent. One such achievement lies in the area of demographic change.

Population and Reproductive Health Policies and Programs

The government of Kenya established the first population program in Africa in 1967 within the Ministry of Health (MOH). However, the national population growth rate continued to increase, and by the late 1970s, Kenya was noted as having one of the highest growing populations in the world (APPRC, 1998: ix; Njogu, 1991).

Factors that contributed to this scenario included a lack of manpower, ineffective Information, Education, and Communication (IEC) strategies, emphasis on child care at the expense of family

Maternal and Child Health (MCH), a lack of promotion for family planning programs, and ineffective coordination of family planning activities. The lack of a strong endorsement of and commitment to fertility regulation by the government has also been noted in various studies (APPRC, 1998; Kokole, 1994).

A change in the government's approach combined with the establishment of the National Council for Population and Development (NCPD) in 1982 has been significant in prompting a turning point in Kenyan fertility rates. The central objective of the population policy is to regulate the country's growth rate in order to attain a balance between population and sustainable development and resources (Republic of Kenya, 1994).

The key strategic interventions included executing Information, Education, and Communication (IEC) practices regarding family planning issues, which resulted in high levels of use for at least one contraceptive method across the country in both rural and urban areas. In addition, the health of mothers and children became a focus, which resulted in a reduction in maternal and child mortality, a reduction in the population growth rate, and an increase in family planning for spacing reasons.

In September 1989, the announcement that fertility transition had begun in Kenya placed the country at center stage among demographers. The 1989 KDHS report revealed that, for the second time in ten years, the country's fertility had declined. Kenya thus registered as "one of the first significant decline[s] in fertility in Africa" (APPRC, 1998; Njogu, 1991) and joined Botswana and Zimbabwe as one of the first three African nations to move towards lower fertility.

The TFR (Total Fertility Rate) declined from an estimated 8.1 in 1989, to 5.4 in 1993, then 4.7 in 1998 (NCPD and Macro International, 1999; 1994).

Both supply and demand factors were upheld during the decline in fertility. The period was also marked by social and economic change in the country, with substantial progress made in increased education levels, reduced mortality, reduced desired family size, reduced age at first marriage, and an increase in the number of women who wanted to stop childbearing. The role and commitment of the government during this time also developed and increased, as previously noted, with women's education and economic stability widely noted as factors that might explain the trend (see van de Walle and Foster, 1990:13 in Bradley, 1995:157).

In regards to supply, a significant increase in modern contraceptive use was noted in various studies (see APPRC, 1998; Fergusson, 1992; Njogu, 1991). Modern methods of contraception were reported to constitute approximately two thirds of the methods used in 1989 (NCPD and IRD, 1989 in Njogu, 1991). The contraceptive prevalence rate doubled from 17% in 1978, to 33% for all methods in 1993, and 39% in 1998 for any method while the figures stand at 27% in 1993 and 33% in 1998 for modern method use. The increase in contraceptive prevalence rate and the subsequent increase in fertility regulation have been linked to political goodwill and a commitment to the population program at all levels, specifically from the early 1980s—including the education and health sectors, with the former enhancing its influence on decreasing demand, and the latter enhancing the expansion and accessibility of family planning programs at local levels (APPRC, 1998: x-xiv).

The accessibility of family planning to women across the country improved significantly during the 1980s and 1990s. The African Population Policy Research Center (1998) noted that, "the percentage of currently married women who were, at most, half an hour away from a family planning facility increased from 23 in 1978 to 69 in 1989 on average, and 15 in 1978 to 73% in 1989 in the rural areas, indicating that there was a substantial increase in the availability of family planning services and an even more dramatic percentage increase specifically for women in the rural areas" (APPRC, 1998: xiii).

This widespread access to family planning, the provision of suitable environments for assessing the reproductive motivations of couples, a substantial and continued decline in the demand for children across the country, and an increased demand for contraceptives are all factors that have been linked to the demographic transition that has occurred in the country.

While arguments surrounding the significance of supply versus demand certainly factor into the decline of fertility, further evidence has shown a significant increase in contraceptive use within the same period—supporting the lauding of the population and family planning programs initiated in the country three decades before. As noted by the APPRC (1998), the improved quality and accessibility of service over the history of the family planning program in Kenya has provided an enabling environment which satisfies the latent demand for spacing and limiting. Thus while other factors such as socio-economic changes and individual fertility preferences played a role in the fertility decline in Kenya, the family planning program is believed to have enhanced the fertility decline (APPRC, 1998: 80).

The fertility decline in Kenya has prompted the interests of demographers to turn to an examination of factors that relate to the sustainability of the decline, while also acknowledging the different rates of fertility transition occurring in the various parts of the country, with urban areas taking the lead.

For many years, Kenya's population program focused almost exclusively on women, and reproductive health services were provided in predominantly female settings such as MCH/FP clinics (Fapohunda and Rutenberg, 1999). While the role of men in the noted advent of fertility decline in the early 1990s remains unclear, the significance of male involvement is currently recognized as necessary for the success of both population and reproductive health programs in the country. Below I present a brief summary of male involvement initiatives in the country sourced from Fapohunda and Rutenberg's (1999) report on Expanding Men's Participation in Reproductive Health in Kenya.

The main organization implementing programs targeting men in Kenya is the Family Planning Association of Kenya (FPAK), established in 1967. This is a national association that began employing programs for men in the late 1980s. The initiatives of the FPAK in this regard included clinical components of male only, as well as male-friendly clinics.

One of the main initiatives has been to establish a specifically male entrance to the Pheonix clinic in Nairobi in 1987. Other efforts include IEC information promoting vasectomy services in 1988 and a large communication program with a theme revolving around reaching out to men—"The forgotten 50 percent"—in 1994. The goals of this program were to redesign family

planning programs to include the needs and concerns of men, develop special programs to change men's negative attitudes regarding family planning, promote spousal communication and support for female contraception, and increase the involvement of men aged 18 to 59 (FPAK, 1996 in Fapohunda and Rutenberg, 1999: 4).

By 1996 in Kakamega—a locale that the current study area was previously a part of—the Kisumu and Nakuru districts had their male only clinics. These catered only to men, and all the service providers were male. The male-friendly clinics involve redesigning conventional clinics to focus attentions on men's privacy and time constraints (see Fapohunda and Rutenberg, 1999).

The non-clinical components of the male involvement initiatives include work place motivators, a multi-media IEC campaign, and service provider training. FPAK has recruited and trained work place motivators in Kakamega, Kisumu, and Nakuru (Mwarogo and Achwal, 1997 in Fapohunda and Rutenberg, 1999: 5). The Men Information Education Campaign (MIEC) seeks to increase knowledge of and spousal communication about family planning among married men who do not practice fertility regulation. Media sources used include radio, television, print, puppet shows, and community meetings (Fapohunda and Rutenberg, 1999: 5).

Previous reviews on the impact of these initiatives, and contraceptive use surveys in general, have revealed positive results among men in the country (Fapohunda and Rutenberg, 1999; NCPD and Macro International, 1999; 1994). Fapohunda's (1999) in-depth study found that specific characteristics were significant for men's participation in reproductive health. These included facilities offering predominantly family planning and STD services; provision of a

range of methods beyond condoms and vasectomy; a guarantee of confidentiality, privacy, and comfort; adequate access to information on choice, the merits of family planning, and its methods side effects; flexible hours and short waiting times in clinics; affordable reproductive health services and free or minimally priced family planning services; male providers to serve male clients; and knowledgeable, friendly, helpful, patient, persuasive, warm, discreet, and trustworthy providers (Fapohunda and Rutenberg, 1999: xii). Other recommendations in relation to these findings included bringing services to men in their work places and recreation centers, and the use of multiple informing methods about family planning and HIV/AIDS—including mass media, funeral ceremonies, chiefs' meetings, and health talks in hospitals (Fapohunda and Rutenberg, 1999: xiii).

In the area under study at the time of the research, male involvement initiatives remained minimal. There were no male-only clinics—the nearest one being the Kakamega clinic referred to by Fapohunda above. Kakamega is currently in a different district, and while some people in the local area had heard about it, few had ever visited and it was mainly known as a clinic for those requiring vasectomy. Vihiga Health Centre and Mbale hospital, however, had what were termed male-friendly clinics in operation. This entailed having a resident male service provider (largely issuing condoms and interpersonal reproductive health counseling) who acted as a community distributor for condoms. Condom provision was noted by the clinic staff to have increased, and this is attributed to widespread multi-media messages, the involvement of local leaders in encouraging male reproductive health, and the availability and accessibility of condoms both at the clinics and in the local kiosks. However, family planning clinics in these

areas continued to largely cater to female clients, and male involvement seemed restricted to condom provision and STI treatment services at the local clinic.

Population of the Study Area and Family Planning

The Vihiga district has one of the highest population densities in the country—more than 1276 persons per square kilometer—implying limited land availability (Republic of Kenya, 1994:7). The 1997 to 2001 District Development Plan describes this as "a phenomenon which calls for intensified food production and promotion of employment - creation opportunities and provision of social amenities" (DDP 1997-2001:15). There were 95,779 households in the district with an average of six persons per household in 1996, and an estimated total population of 530,873 with an annual growth rate of 2.98%, per year, (DDP 1997-2001).

The majority of the Kenyan population is youthful. The population in the district is comprised of 57% dependants with 53% of the population below 14 years, and 4% being 59 years and above. The dependency ratio is about 1: 1.4 (Republic of Kenya, 1994:7).

The infant mortality rate in the district stood at 64:1000 in the 1998 KDHS, while the national average was 70:1000 (see NCPD and Macro International, 1999). The district is also experiencing a high incidence of HIV and AIDS seropositivity. In 1995, the seropositivity rate from ante-natal clinics and referred suspect patients was about 21%. Areas hit hardest by HIV and AIDS are Majengo, Mbale, and Chavakali on the main Kisumu-Kakamega highway, Serem

on the Vihiga-Eldoret route, the Kima area in the Emuhaya Division, and Luanda Town on the main Kisumu-Busia highway.

The continued decline of infant mortality rates in the district has had further implications for population figures as the district reports one of the highest fertility rates in the country. The prevailing presence of HIV and AIDS has also affected the demographic trends of the district, with an increase in adult mortality and a general decline in life expectancy. The high fertility rates and increasing HIV and AIDS prevalence rates in the district suggest the need to address both the reproductive and health needs of the people in conjunction with each other, a fact supported by the heterosexual nature of HIV transmission in the area.

Western Province houses the districts registered as experiencing stagnant current contraceptive use at the provincial level within the five years prior to the 1998 KDHS. The Province's rate of 30.2% was the same in the earlier 1993 KDHS (see NCPD and Macro International, 1999; 1994). The accessibility of family planning in the district is, however, one of the highest in the country's rural areas. There are fifteen family planning service delivery points in the District, all of which offer modern contraceptive methods (Republic of Kenya, 1994:39). The majority of the population (90%) in the district is reported to be aware of family planning, but the actual use of contraceptives remains low despite approval rates in excess of 60% (see NCPD and Macro International, 1999; Republic of Kenya, 1994).

The Ethnic Groups

Ethnic groups in Kenya are identifiable both by the languages they speak, and the area of residence they traditionally occupy. Specific regions of the country tend to house specific ethnic groups, with each group's communities sharing fairly similar cultural traditions. The demographic transition occurring in Kenya—apart from a regional analysis—has also provided interesting findings based on ethnicity— supporting the significance of cultural traditions in the fertility changes. The Luhyia—who form the wider ethnic group[1] participating in this study—have recorded a relatively higher fertility rate despite increased accessibility to family planning in the villages. The communities who occupy the study area are the Abanyole of the Luanda and Emuhaya divisions, the Maragoli of the Vihiga division, and the Tiriki of Kaimosi and Serem. Below is a brief description of the Maragoli, the Abanyole, and the Tiriki. The description is partly extracted from Bradley (1995), and further supported by study field notes.

The Maragoli or Logoli, the Abanyole and the Tiriki

"Maragoli" refers to the traditional place-name for one of the seventeen Abaluyia sub-nations occupying the hills of Western Kenya for the past 500 years (see Bradley, 1995: 163). From the name Maragoli, the residents of what is now the Vihiga District's, *ebulogoli* are referred to as the "Logoli" while their neighbours are called the Abanyole and the Tiriki. The Logoli occupy the Vihiga and Sabatia divisions, while the Abanyole are found in the Emuhaya and Luanda

[1] 100% of the FGD participants and at least 87.5% of the couple sample of the KDHS had both spouses belonging to the Luhyia, while the remaining 12.5% had wives from other communities, namely seven Kalenjin, four Luo, and two Kikuyu.

divisions. The Tiriki reside in Kaimosi and Serem and form one of the smallest Luhyia communities occupying parts of the Vihiga and Kakamega districts.

These Luhyia communities are horticultural, growing a variety of grains, trees, roots, and vegetables as well as keeping cattle for milk, meat, and bride-wealth. Tea is the main cash crop, and maize is the main staple food grown. They cultivate their land with hoes—a practice enhanced by the fact that most farms are too small to cultivate with a plough (Bradley, 1995:163). According to Kipsat, Maritim, and Okelebo (2002:2) the district households have an average land holding of 0.6ha—way below the 1.4ha recommended for subsistence food purposes (FAO, 1999).

The land scarcity, high population growth rate over the years, and subsequent highest population density in the country have all impacted heavily on these communities' lifestyles. While homes used to be situated on family land passed down from parents with brothers of the same family staying close together, the land scarcity has prompted a huge increase in the out-migration of those who can afford to buy land elsewhere (Bradley, 1995; Fergusson, 1992; study field notes). With its population density (exceeding 2000 people per square kilometre), Maragoli has been described as a "neighborhood" or "bedroom community" because of the close proximity of the houses (see Bradley, 1995: 162).

Marriage

The Luhyia communities are both patrilineal, and patrilocal. Traditionally, a wife leaves her father's home to occupy new home provided by her husband and his family. The children she

bears belong to her husband, and in cases of separation or divorce, she is expected to leave the children behind at her husband's home. Marriage among the Maragoli, the Abanyole, and the Tiriki essentially sustains the patrilineal structure (Bradley, 1995; study field notes).

Marriage among the Luhyia communities was traditionally regarded as a contract between two lineages, whereas it is currently closer to a contract between two extended families. Bride-wealth is the most important symbol of the customary marriage. It signifies the entitlement of the husband. While bride-price traditionally consisted of farm animals—specifically cows—today a capitalization of the practice has developed, and while at least three cows have to be remitted to the girl's family, the rest of the bride-wealth is more often negotiated and provided in monetary terms. Interestingly, this custom remains solidly in place despite the various modifications, even in cases of Christian church weddings. Most couples, including the educated ones, undertake a mixture of modernised traditional practice and Christian church wedding, the former preceding the latter (study field notes; Bradley, 1995).

Bride-wealth is still regarded as a means of strengthening the relationship between two families or lineages, as well as a sign of appreciation to the girl's family for the birth and care of the bride (Lukalo, 1973; Bradley, 1995). According to Lukalo (1973. 144), the Logoli were basically monogamous, with polygamy prompted by a lack of sons, infertility, unfaithfulness on behalf of the wife, or a wife's illness or inability to perform household chores.

Family Livelihood and Child Rearing

Land has traditionally been the main source of family livelihood in this horticultural community. However, even today, the majority of Logoli, Abanyole, and Tiriki women lack a full entitlement to land ownership. Traditionally, access to land was secured by the wife, whose labor and that of her children was important for the livelihood of the family. The man was thought to have made a specific and significant contribution upon providing the land for his wife and children to work. The direct responsibility of providing for the family, however, lay with the wife and mother (Bradley, 1995; Lukalo, 1973).

While the communities are largely patrilineal, land scarcity has led to young married couples moving from family homesteads to individually bought pieces of land in neighboring areas. It is expected that for these couples, living away from their extended families, conjugality is enhanced—presenting a better potential for partnership in family planning (Livingstone, 1989; Munroe et al, 1969).

In present times, a variety of income generating activities is undertaken by assorted family members to maintain family livelihood. With the high emphasis on education prevailing among the Maragoli, Abanyole, and Tiriki, it is important to note their dependence on outside sources of income for survival. Today both women and men in Vihiga seek out non-farming sources of income because of the low returns that agricultural activities provide with the land scarcity scenario in place. Women combine farming with other activities including selling vegetables, grains, or dried fish, running a shop, making pots, working as day laborers picking tea or weeding, or assisting the husband with a small business (Bradley, 1995; Fergusson, 1992).

Most men work outside the home, many outside of the area—providing remittance to their wives regularly or irregularly. The wife is frequently unaware of when the next remittance will arrive—a situation that makes her involvement in income generating projects outside the home a necessity. The terms "unemployed" and "farmer" in this region are quite ambiguous, providing a category for a wide range of activities that would otherwise define the person's "occupation" (Bradley, 1995; Fergusson, 1992; study field notes). Young girls and boys in school aspire to careers like teaching, nursing, and administration in neighboring towns or major cities—further endorsing out-migration and the dependence on outside sources of income for survival (Bradley, 1995).

Site Description

This study was undertaken in the Vihiga district of Kenya. It is one of the smallest of the seven districts in Western Province. The other districts are Kakamega, Bungoma, Busia, and Mt. Elgon. Vihiga borders Kakamega to the North, Nandi district to the East, Kisumu district to the South, and Siaya district to the West and occupies 613sq.km (Republic of Kenya, 1994:1).

Vihiga district is divided into five administrative divisions— Emuhaya, Luanda, Sabatia, Tiriki, and Vihiga. There are a total of twenty-four locations in the district distributed proportionally according to the size of the divisions. Emuhaya, Luanda, and Vihiga have four locations each,

while Sabatia and Tiriki each have six. The study involved three administrative divisions in the district—Vihiga, Luanda, and Tiriki.

While Kenya has experienced a substantial fertility decline (total fertility rate has fallen from 8.1—recorded in the 1978 World Fertility survey—to 4.7, according to the 1998 Kenya Demographic and Health Survey), reproductive change has been regionally uneven. Western Province is still in the early stages of fertility decline while other areas like Central and Eastern Provinces have already made substantial improvements in contraceptive use and fertility regulation (NCPD and Macro International, 1994). With a fertility rate of 5.63, Western Province had the highest fertility rate while Central and Eastern Province recorded fertility rates of 3.67 and 4.68, respectively.

Socio-Economic Set-Up

The district has six urban centers that lack the industries to attract larger populations, with relatively few people living there. However, the rural homes of a majority of people in the district are not very far from these centers. All the major towns in the district are transit centers on major routes—well served with transport means, accommodations, and catering businesses. This tends to attract young people in search of available employment, and young men can be observed idling. The urban centers also boast the availability of postal telecommunications, banking, and supply services.

Subsistence agriculture is the basis of the local economy. The district produces mainly maize, tea, and beans. However, the agricultural produce tends to be insufficient, and the district relies heavily on importing foodstuffs from neighboring districts like Mt Elgon and Bungoma. The high density of population in the district has put pressure on land subdivision, resulting in unproductive pieces of land that create a strain on subsistence. Due to high subsequent land subdivisions, the average farm size per household was recorded as 0.6ha (Republic of Kenya, 1994: 21-22).

A majority of the households located away from the urban centers engage in the production of maize, sorghum, sweet potatoes, beans, cassava, assorted vegetables, sugarcane, bananas, and avocados, among others. They also cultivate their land with hoes. The land scarcity has influenced their culture and traditions. The concept of family land inheritance has changed over the years to identify the youngest son as imperatively expected to inherit family land, with implications for the endorsement of searching for land elsewhere by elder brothers, especially when this is affordable.

The fruits and horticultural crops are mainly grown in the Tiriki West, Vihiga, and Sabatia divisions with the produce sold at the local or border markets. While labor is available, transportation costs hinder the marketing of such produce from smallholdings to outside markets for higher income. Livestock is also reared on a very small scale by some households in the district, mostly local stock due to a lack of adequate feed for pedigree animals. Household incomes in the district are mainly derived from agricultural and livestock production, wage employment, and the informal sector (Republic of Kenya, 1994: 25). While the people have had

to move into the cash economy for basic subsistence, the absence of economic opportunities is still apparent. Unemployment is high, and there is a growing presence of idle youth with little to do to earn a living. Unemployment is heavily blamed for the noted increase in social ills throughout the district.

Commercial activities in the district only employ about 7% of the district's labor force. The activities involved include maize milling, general merchandise, garages, carpentry, welding, and the sale of second-hand clothes. The low levels of commercial activities is attributed to inadequate working capital, low levels of business skills, and low demand arising from low and unreliable incomes. The informal sector plays a crucial role in the provision of employment and training opportunities. The main activities in the informal sector include carpentry and woodwork enterprises, and brick-making. Petty trading appears as the most practiced commercial activity in the area. Of the total labor force, over 47% are engaged in small farm agricultural and livestock production activities, 16% in wage employment, and 13% in the informal sector. The majority of the wage employment labor works in the public sector, including government and state corporations. Wage employment is concentrated in Majengo and Mbale towns, which are the main urban centers. Other Centers are Chavakali, Jeptulu, and Luanda (Republic of Kenya, District Development Plan 1997-2001: 30-43).

The district's high population growth has directed productive resources towards consumption rather than investment in an attempt to sustain the young and dependant population. The high population is also causing rapid land subdivision, parsing land into unproductive units via traditions of land inheritance. The continued subdivision of land has further caused a decline in

productivity. The existing socio-economic facilities like schools, dispensaries, and water schemes are over utilized while the food produced in the district is inadequate to feed the people (Republic of Kenya, 1994:43).

While the high population growth in the district is a major factor, the role of poor governmental policies has had specifically adverse effects on rural families in the district specifically, and the country in general. Linked to the world economy, the reduced prices of tea and the importation of cheap maize have resulted in a reduced market for local maize producers. Furthermore, a generally poor and declining economy has resulted in little job creation as well as a poor absorption of the educated skilled and unskilled populations.

Vihiga Division

Vihiga division is situated at the center of the district and forms the District Headquarters with the offices formerly at Vihiga that have moved to the Mbale town Council. While the new District General Hospital was undergoing completion at the time of study, Vihiga Division has other government health dispensaries distributed throughout the division.

The study areas in Vihiga division were Vihiga[2], and Mbale. Government dispensaries serve each area, and Vihiga and Mbale also have a couple of private clinics each. All the government health units provide family planning services, but the Vihiga health unit was the only one with male (two) CBDs. None of the centers had male-specific clinics for Reproductive health,

[2] The name Vihiga here is used in reference to the area where the initial District Headquarters was situated. In the thesis as a whole, reference is made to Vihiga district housing the entire study. Vihiga division housing Mbale and Vihiga area as explained here, and Vihiga fgds to mean FGDs carried out in Vihiga division. When reference is made to "Vihiga" without qualifying it in the data analyses chapters, this applies to Vihiga district.

however, and this was often quoted as a dilemma by most men in the study citing the congestion of the existing clinics with women and children—an environment not conducive to men seeking reproductive health care.

While the housing in Vihiga consists of mainly family residential homes, Mbale center is occupied by civil servants, and rental housing is available. Majengo—which lies between the two centers—provides rental housing for the majority of the staff in both formal and informal employment within the division. It is important to note that mobility within the three areas is easy, and many of the people who live in Majengo and Vihiga still commute to Mbale to work, with others coming from as far as Luanda and Emuhaya.

Since Mbale houses the new District Headquarters, the district hospital, and the police station (all of which were under construction at the time of study), the potential for the center to grow into a major town is great. The Mbale district hospital is used by people from throughout the district, while Vihiga has only a small health center that mainly covers maternity, pediatrics, and general practitioning.

Luanda Division

Luanda division houses one of the major markets in the district where traders from both within and without the division trade their produce and goods. Small-scale enterprises are common, and the main activities include the sale of second-hand clothes, carpentry, hawking, mechanical repairs, and small shops. The market has developed a heavy presence of idle youth who have dropped out of school or finished their educations but failed to secure employment. These youths

are mainly engaged as *matatu*[3] touts, since the market also serves as a transport terminal on the Busia, Kisumu, and Kakamega routes.

A number of hotels, lodgings, and rental rooms can be found surrounding the market—mainly serving traders who sometimes stay over night with their produce from outside the district. The residential homes are different. In some houses, the extended family occupies a residential compound populated with a number of huts. Each brother's family household occupies their own hut, with the parents' hut built nearby. It is a common occurrence today to find that some of the elder brothers have built their homes away from the original family land as the heavy population density has taken its toll on the family land holdings. Inheritance of land is no longer a guarantee for all the males in the family. Many houses are made of bricks with corrugated iron sheets for roofs. There are also mud houses with corrugated iron sheets for roofs. Grass thatched houses can also be found, although this is not as common today as it was in the past. The grass thatched structure usually found in all compounds is the kitchen, which is normally separated from the main house.

The setting for the study group discussions in Luanda was at the Epali health center—a twenty-minute walk from Luanda market. The health center is government owned, and bigger than the Vihiga health center. It consists of hospital facilities including a laboratory, and residential houses for the doctors and some staff. At the time of this research was conducted, the health center was in crisis, trying to bring an extensive outbreak of cholera—a highly infectious, water-

[3] This is the public means of transport, privately owned by various individuals. The matatu business in Vihiga and in Kenya as a whole attracts a large number of youth who have no other means of subsistence. Most of the youths are employed as conductors on a temporary basis, or as casual laborers while the bulk of them work at the stations throughout the day as touts—wooing travellers and loading the vehicles with luggage.

borne disease—under control. A number of deaths had already been recorded due to the outbreak, and public health staff at the hospital were educating the community on preventive measures and providing medical care to people who had already succumbed to the disease.

Serem

Serem is within the Tiriki division of the District. The area is occupied by the Tiriki people, who form a sub-sect of the Abaluhyia ethnic group. The area's clinic is situated next to a shopping center which houses a few shops, milling points, and a bank. While the shopping center is way off the main road from Nandi, it is linked to the Highway by a dusty road populated by a public transport system of old vans. They all look un-roadworthy, but they are many people's only link to the rest of the district.

Unlike Majengo, Mbale, and Luanda, Serem has fewer rental residential houses, and most people live in and work near their own homes. The house structures are either brick with corrugated iron sheets for roofs, or mud with the same roof (this seems most common), or grass thatched houses. Hardly any of the homes away from the shopping center have access to electricity.

The hospital also serves as a center for maternity and pediatric care, and is situated near the shopping center with most of the nurses who man the clinic coming from the nearby area. Women and their children are the main clients seen at the clinic, which is not fully equipped. Referrals are usually made to the Kaimosi Hospital in the neighboring division, which means that processes like vasectomy and tubal ligation can only be performed elsewhere.

Kaimosi

Like Serem, Kaimosi is also inhabited mainly by the Tiriki, who are part of the Luhyia ethnic group in Western Kenya. The area around the hospital is fairly developed, featuring a school, a post office, a Teacher Training college, and a village polytechnic—all located along the road that links the hospital to the main road while the shopping center is further along the highway. However, the place cannot be said to be sprawling with shops or trading activity when compared to Majengo in Vihiga, or Luanda.

The division is predominantly agricultural. Tea is grown and sold to a nearby new factory alongside other subsistence crops—mainly maize and beans. Humble housing, mostly of mud with corrugated iron sheets for roofs, is commonly found along with some grass-thatched homes. The homes visited had humble belongings, with a radio featured as a consistent possession in all the homes.

Commonly held local perceptions gathered from informal conversations revealed that the Tiriki among the Luhyias in Vihiga are regarded (mainly by others) to hold onto culture more strongly than the Abanyole of Luanda—who are called ‘the white people of Luhyia-land’. Events like circumcision ceremonies are more common among the Tiriki, and women from Luanda who married into the culture described Tiriki men as traditional (meaning chauvinistic).

Conclusion

The scenario that can be observed in the district is one of transition. On one hand, we have the traditional, pro-natal factors of the patriarchal lineage system promoting large family size desire, polygamy, and clear cut gender roles in family structure reducing male involvement reinforced by traditional marriage contracts and pro-natal implications. While many of these factors cannot be said to have completely transformed, a significant change in the district's socio-cultural and economic life is seen in the glaring scarcity of land in the area. Scarcity of land, as described above, influences both the economic and cultural lives of the people. Land scarcity has not only negatively affected land inheritance traditions, but also had an impact on the values and substance of child-parent wealth flows. Education is now widely upheld in the community as the significant inheritance item parents can provide for their children (see, Oyosi, 1997).

The prevailing socio-economic and cultural situation in the study area provides for an increased emphasis on fertility regulation for both men and women in the area. Other writers note the significance of other contextual factors in bringing about change in fertility behavior in rural parts of Kenya. These include—apart from women's access to income generating activities—ideological changes which allow women to control their activities which serve to decrease the need to use children as labor (see Rothschild and Mburugu, 1986).

An important factor in the present research that needs to be followed-up is the realization that the social burdens that result from the increased economic costs as presented by contextual changes are either not homogenous, or do not effect men and women in the same manner. While

economic costs may reduce the demand for children among males, the concepts of family planning and contraceptive use present other gender-related dynamics that the man has to come to terms with. While the man's role in dealing with the imbalances is imperative for fulfillment within the couple, the possible social costs for the man in doing so cannot be ignored. Partnership in reproduction has gender implications that (the economic situation aside) may not auger well with the men.

CHAPTER FIVE

Data and Methodology

Introduction

This chapter provides details regarding the data and methodology undertaken in this study. The data for the study is both quantitative and qualitative, seeking to integrate both the KDHS data's statistical analysis, and the Focus Group Discussions (FGD) data to provide a more meaningful understanding of the results.

The research employed data and methods that worked to realize the main objectives of the study within the conceptual framework presented in chapter three. The use of both qualitative and quantitative methods is key in applying the conceptual framework. The numerical analysis traditionally used in demography is enhanced by qualitative methods that provide further insights in examining social and political-economic processes at various levels of society that inform fertility behavior between married couples, while underlining the agency of the individuals as they engage in spousal family planning negotiation.

The chapter begins with the description of the KDHS survey data used in the study, providing information regarding the original data file used, specific data selection, and the formation of the study data set. I then provide an assessment of the quality of the KDHS data, examining the variables relevant to the study, followed by a description of the qualitative data (FGD data, the selection process and qualifying factors, and the data collection processes). The strengths and weaknesses of the FGDs are also reviewed.

As with the choice to combine the qualitative and quantitative methodology, the use of specific data in examining the study objectives is further related to the conceptual framework in both the data selection and analysis. This is discussed further in specific sections on quantitative and qualitative data below, and the data analysis section at the end of the chapter.

Quantitative Data

Demographic Health Surveys are held at regular intervals in most developing countries by Macro International, in conjunction with the national governments of the participating countries. The studies are designed to collect demographic and health data relating to fertility and mortality trends, health indicators, and general socio-economic indicators collected from urban and rural regions of the country.

The 1998 Kenya Demographic and Health Survey (KDHS) was a nationally representative survey of 7,881 women (aged 15 to 49), and 3,407 men (aged 15 to 54). The KDHS data is divided into the individual file (data from all the women interviewed), the men's file (data from all the eligible men interviewed), and the couple file (data from women and men interviewed who were also married partners).

The National KDHS sample was obtained by the 1998 KDHS from a national master sample maintained by the Central Bureau of Statistics. From this, 536 sample points or clusters were

drawn. From late 1997 to early 1998, the Central Bureau of Statistics conducted a household listing in each of the 536 clusters. From these household lists a systematic sample of households was drawn with an average of 22 households in urban clusters, and 17 households in rural clusters for a total of 9465 households. All women aged 15 to 45 were to be interviewed in the selected households and every second household from these female clusters was selected for the male surveys with all men aged 15 to 54 interviewed. Age was the only other factor of eligibility, apart from belonging to the specified households (NCPD and Macro International, 1999).

Western Province, whose data is used in the current study, formed part of the sample represented by the two districts involved—Bungoma, and Kakamega. The current study makes use of the quantitative couple data file from Western Province which revealed interesting insights regarding fertility demand, communication, and contraceptive use intentions between spouses.

This file is derived from the linkage of women whose husbands also happened to be selected and interviewed as a result of belonging to every second household, meeting the age criteria, and being one of the eligible men actually available for interview in the particular households. As a result, the couple file contains data whereby each case is not just a man or a woman, but a couple. For each case selected for this study, two similar variables account for the husband and the wife respectively. This has enabled the study to examine husbands and wives who make up specific couples—revealing interesting insights regarding fertility demand, communication, and contraceptive use intentions between spouses.

While the KDHS was designed to produce reliable national estimates and urban and rural estimates, the sample design has also been noted to allow for estimates of selected variables for the rural parts of fifteen over-sampled districts (see NCPD and Macro International, 1999: 6). Selected districts were over-sampled in the 1998 KDHS in order to produce reliable estimates for certain variables at the district level. The fifteen districts that were targeted in both the 1993 and 1998 KDHS included the Kakamega and Bungoma districts, which form the Western Province of Kenya.

Data Identification

The first step in working with the KDHS data was to identify the variables from the couple file that were relevant for the present study. It became clear early in the data examination that the couple file would be most applicable to the research objective of examining couples' role in family planning. While individual male and female files exist, they were comprised of women and men who might have been unmarried, or their spouses did not participate in the study sample.

The KDHS couple file, on the other hand, is comprised of married men and their partners. While the husbands and wives were interviewed separately on different occasions, the couple file data allows for couple identification and linkage to various variables on fertility, HIV and AIDS prevention, and descriptive variables that offer a picture of the dynamics of family planning knowledge, preferences, communication, and application.

Having justified the use of the couple file, the next step entailed identifying the specific variables that separated Western Province from the rest of the country. The KDHS provides both district and provincial level data. As mentioned earlier, the qualitative data was collected from Vihiga district, which is part of Western Province.

While the quantitative study could have been directed at the district level to keep in line with the fact that qualitative data was collected from one of the four districts in the province, province level quantitative data proved more viable for statistical analysis. Only fifty-five couples' cases could qualify for this study at the district level, while this number increased to 176 when we considered the data at the provincial level. Given that the province largely forms the home for the Luhyia ethnic group, the 176 number was considered a better option in terms of statistical analysis, and hence the Western Province quantitative data is used for the current study. It is also important to note that a t-test revealed no significant difference between the district, and provincial data. Restricting analysis to Western Province further serves to provide contextual background that is applicable to the qualitative focus group participants. While focus group participants are not the very individuals interviewed in the KDHS, the Western Province data specifically relates to an environment, and the respondents who live within it tend to share socio-cultural and economic environments with the focus group participants.

Justification for the Use of the KDHS Sample

As noted above, this study made use of the 1998 KDHS couple sample from Western Province for the quantitative analysis. This effectively provided a sample of 176 couples to work with. This sample allowed for significant analysis in terms of examining comparisons between spousal

family planning and fertility regulation behavior. This was particularly applicable given the objectives of the study. This comparative element forms the significant focus in answering the study's objectives.

On the other hand, a sample of 176 is too small for complex statistical analyses like regression. Regression analysis would have allowed the study to specifically examine the relative role of different variables in enhanced or decreased spousal communication and contraceptive use. This study appreciates that the use of a larger sample could have achieved a wider range of statistical analyses on variables surrounding couples' fertility regulation behavior.

The need for future studies to explore the use of larger quantitative samples, including pooling KDHS couples data from 1994, 1998, and 2004 to obtain a larger sample is recognized. This would also provide an opportunity to identify significant trends across the years. However, differences or growing similarities in terms of specific time periods should be identified and compared, so time specific data such as the kind used in the current study sample will remain significant in the long run, despite its obvious limits.

A general observation that can be made here relates to small-scale studies in general. Such studies, usually qualitative in nature, have gained importance in the field of population studies with the realization that the focus on community studies is crucial in understanding population issues such as family planning. The challenge of combining such studies with quantitative data is to provide wider representation of the local community remains. Large surveys such as the

KDHS, which provide very significant demographic and health data, are most applicable at the country and inter-region levels.

While this study recognizes the limitations of its smaller sample, it notes the significance of the sample in the way it provides a more randomized representation of the local community in regards to family planning attitudes and practices.

Variables Selected and the KDHS Questions Used

The selection of the provincial data applicable to this study was followed by the selection of variables which were specifically appropriate for the study. In order to answer the research questions using both the qualitative and quantitative data, variables that are important in understanding the research questions were selected from the KDHS file. The variables selected include the current age of the respondent; (wives' and husbands') ages in five-year groups; the highest educational level; family size; knowledge of family planning; contraceptive use; discussion of family planning with partner; intention to use contraceptives; respondent's approval of family planning; husband/wife approval of family planning; preferred waiting time; ideal number of children; total children ever born; number of living children; fertility preference; desire for more children; and wife's/ husband's desire for more children.

While the KDHS prepared two separate questionnaires for men and women, the couples' questions were extracted by KDHS to form the couples' data set. The questions selected for this study from the KDHS questionnaire are noted below, while the complete questionnaire is provided as an appendix at the end of the dissertation. Given that the study concentrated on

Western Province, the province variable was used as the selection criteria to form the data set for Western Province from the Kenyan couples' data set as provided by KDHS.

The age, education (question 108), family size (question 201), and occupation (question 117), and resulting variables in the data set were chosen to provide the basic background characteristics of the respondents. These variables were further analyzed to show variations in family planning approval and discussion.

The questions and resulting variables regarding knowledge of contraceptive methods (question 301), contraceptive use, (questions 303 and 305), and family planning approval (question 514), served to provide specific findings for the first objective of the study regarding spousal perceptions of family planning. While these findings did not adequately answer the question posed, they did provide comparisons between the perceptions of husbands and wives, as well as displaying the need to examine this issue further.

The questions and resulting variables addressing spousal family planning communication (questions 518 and 522), fertility preference, (question 505), spouse's perceived fertility preference (question 523), ideal number of children, intentions to use contraceptives (questions 508 and 509), and spousal approval (question 521) are all used to compare the responses of husbands and wives and examine spousal reports regarding family planning discussion and contraceptive use.

DHS Data Quality

The limitations of data quality in research data, including DHS in Africa has frequently been noted by various scholars. For DHS, the data problems include non-sampling and sampling errors. Looking at the former, non-sampling errors include misreporting of age and or events, the mis-recording of information by the interviewer, and errors in questionnaire design (see Macro, 1990:1). The variables relevant to our study that are commonly noted in sub-Saharan DHS surveys include age misreporting, and the misreporting of how many children have died.

According to the DHS methodological reports, age "heaping" (the reporting of ages ending in certain preferred digits rather than true age) is most common in sub-Saharan Africa DHS and other surveys. While this report does not specifically address Kenya, the general picture—consistent for sub-Saharan Africa—is that of a high incidence of age heaping. Age misreporting may result in an individual's exclusion from eligible range for interview, pushing out women and men who should technically form part of the sample. Age misreporting is further associated with low education levels where people honestly do not know their exact age.

For this study, apart from cases of a "reduced" or "inflated" sample, age misreporting may interfere with analysis in terms of understanding how age difference between husbands and wives might influence their family planning and communication dynamics.

Misreporting may also occur in relation to children's ages, a factor that again may impact on our understanding of a couple's intentions for contraceptive use and the timing of their family planning communication, among other things. According to the DHS methodological reports,

however, estimates of contraceptive prevalence appear to be more reliable even across surveys in sub-Saharan Africa. The reasons are not clear, but the fact that the questions separate contraceptive use in the past twelve months from whether or not an individual has ever used contraceptives may be of significance. The fact that this is a very prominent variable in our study significantly boosts the sense of the data's reliability.

The misreporting or under-reporting of child deaths is noted in sub-Saharan African surveys. The (1990) DHS methodological report places the impact of this under-reporting of child mortality at 4% underestimation. The factors for effecting child mortality misreporting include intentional omission, oversight, and non-distinction between child death and miscarriage. Given that the death of a child is expected to have implications on fertility preferences, the under-reporting of child deaths would influence the accuracy of linking this variable to spousal communication or fertility preferences and comparisons.

It is important to note that most of the observations regarding the quality of DHS data are based on older DHS I studies. DHS II and DHS III have been significantly improved, particularly in countries where the rates of education have enhanced, downsizing errors in individual and age misreporting, for example. Given that contraceptive prevalence rates have already been proven reliable, it follows that one can regard the data as appropriate for purposes of further analysis regarding family planning among married couples, although the issue of data quality will remain a factor in all major surveys, DHS included.

Questionnaire Design Errors

The DHS data, while providing valuable information on various trends in fertility regulation, can be identified as imprecise in the formation of specific questions. Specific variables are examined in the context of question design and its influence on the study's findings.

A case in point is the variable on **approval for family planning**. Respondents were asked whether they and their husbands approve of family planning (in separate questions), and the answer options are "approve", "disapprove", or "don't know" for both questions.

Approval for family planning:

DHS question:

Would you say that you approve or disapprove of couples using a method to avoid getting pregnant?

Approves……..1

Disapproves……2

No opinion……..3

While the approval question in the DHS provides data regarding respondents' or their wives attitudes regarding family planning, the data collected by these questions remains unspecific and ambiguous. The respondent or their partner may approve of family planning generally, yet disapprove of a certain method. Exactly what the respondent is choosing to refer to in answering this question may not be absolutely clear. As Chikamata (1996) noted, more recent DHS studies reveal increasingly positive attitudes about family planning on behalf of men in sub-Saharan Africa, although "approval for whom" still remains a question. The wording of the above

question fails to reach the specifics of the respondent's approval or disapproval of contraceptive use. It does not address whether the respondent specifically approves of his wife using contraceptives to avoid pregnancy, or just generally approves of the use of contraceptive methods by others for fertility regulation. The question is non-threatening in the sense that it does not require the respondent to draw from their own personal experiences.

Chikamata (1996) argues that while the rate of approval for family planning has risen in general, it is not clear if these positive attitudes extend to their partners. This discrepancy is brought into focus when the approval for family planning is examined within the context of contraceptive use versus the intention to use. While the level of approval reported by men is high, their actual intention to use contraceptives remains low. In some studies, approval for family planning among married men may also be dependent on reference to a specific wife. In cases where polygamy is high, this may distort the findings, especially if it is not clear which partner is being referred to. A further examination of husbands and wives nature of approval of family planning, paying more attention to salient factors like "approval for whom" (specific wife, or for society in general), is made possible in this study with the use of qualitative data.

The question posed to husbands and wives regarding their perceptions about their partner's attitude towards family planning was worded as follows:

Do you think that your wife or woman you live with approves or disapproves of couples using a method to avoid pregnancy?

Becker (1996:295) notes that again, the question lacks precision. The husband may disapprove of a specific method, but approve in general of family planning, while the wife is sensitive to her partner's attitude while he answers, prompting her to answer in a guarded way. The same could also be said of the wife.

Looking at the variable on **spousal communication**, various studies have significantly related partner communication to family planning involvement (see Greene, 1997; Odhiambo – Omondi, 1997; and Ezeh, 1993). Communication about fertility regulation between couples is expected to help identify similar family planning attitudes and intentions between partners, and in so doing, enhance active involvement and contraceptive use.

DHS question:

How often have you talked to your wife/the woman you live with about family planning in the past year?

Never……..1

Once or twice……..2

More often……..3

Relating the findings for this question to the respondent's actual family planning involvement requires more than is revealed in the DHS data. The quantitative question seeks to find out whether couples had communicated about family planning, and whether they did so once, twice, or more often. This data covers only the occurrence or non-occurrence of couple communication.

In order to effectively relate communication to contraceptive use potential for either couple, salient factors of communication must be examined. Thus the content of couples' communication, the timing, the nature of communication, and the resulting consequences are all highly relevant factors that are lacking in the collected DHS data. The inconsistencies between communication rates and family planning involvement registered in the KDHS (1998) at least provide the opportunity or rationale for further examination of communication between couples using qualitative data.

Fertility preference is another variable that raises questions regarding its collection in quantitative studies such as the DHS. Bongaarts (1993) underscores the demand for children as a major component of completed fertility. He states that a change in the demand for children should lead to a change in the supply of children—*ceteris paribus.* It follows that an explanation of changes in demand should yield an understanding of changes in the supply of children. Fapohunda and Poukouta (1997:2) noted that when desired fertility is high, it provides the motivation to raise large numbers of children, and when it is low, it should motivate to apply fertility control measures. An analysis of women's (and men's) desired family size could enhance our understanding of this dynamic.

The questions posed by DHS while seeking data on desired family size also attracts criticism. As Fapohunda and Poukouta (1997:2) point out, two main criticisms have been leveled against the conventional measurement of Desired Family Size (DFS). One relates to questions of a post-facto-rationalization bias. Respondents may rationalize their desired family size to be in line with their existing family size at the time of the interview, and may quote desired family size figures

similar to their actual family size. Such data conceals objective numbers for desired family size. The other criticism relates to the ability of respondents to give numeric responses to questions related to DFS, particularly in settings where fertility decision-making is beyond the control of the individual women (ref to Ascadi et al., 1990, in Fapohunda and Poukouta, 1997:2).

The conventional measure of Desired Family Size is also criticized for ignoring the real possibility of change in fertility preferences over the reproductive life course of the woman. Change in fertility preference could be influenced by overlapping cultural, socio-economic, and physical realities which define the relative power of men and women in decision making and further cause revision of fertility preferences (see Mhloy, 1994; Rasul, 1993 in Fapohunda and Poukouta, 1997). Rashil (1995) attributes non-numerical responses to this type of DFS question to a great deal of ambivalence on behalf of individuals who are not sure what might happen in the future.

Criticism notwithstanding, the significance of the measure of DFS as undertaken by the DHS is recognized. Firstly, no other measure provides an equally effective index of the potential for change in family size in developing countries (Ware, 1974). Secondly, it reflects the norms and culture of a place (Bankole and Westoff, 1995)—particularly those that are related to the value of children (Kent and Larson, 1982). Thirdly, the literature reports significant correlation between DFS and fertility behavior in different contexts. An analysis of DHS data from eighteen developing countries revealed considerable agreement of stated preferences and demographic behavior among women in these countries (Bongaarts, 1991). The study found that 85% of the respondents whose actual fertility exceeded their DFS said they did not want anymore children.

The Post-facto-rationalization argument has also been challenged when analyzing longitudinal data that provides the opportunity to observe the respondents across their reproductive life course (see Campbell, 1994 in Fapohunda and Poukouta, 1997: 4; McCarthy, 1987; Knodel and Prachnabmoh, 1977). Recent data continues to give credit to questions on DFS (see Fapohunda and Poukouta, 1997: 4). These studies found significant variation in DFS based on age, sex, education, place of residence, mass media exposure, age at first marriage, expected education for children, extended family ties, and number of surviving children. Other factors that have been found to be highly correlated with DFS are gender composition of children, knowledge of modern contraception, infant mortality, and old age security (see Fapohunda and Poukouta, 1997: 4).

Examining Desired Family Size is important for the current study in determining the potential for change in family size, and partly as a reflection of the norms and culture around the value of children in the study area. However, in order to strengthen the measure of DFS for both purposes, a comparison of husbands' and wives' DFS is undertaken with the aim of further determining spousal influence on each other with respect to the actual predictability of family size change and family planning involvement. The norms and culture of the people in relation to changing family size, value, and cost of children have been checked and evaluated qualitatively. Apart from understanding the spousal influence and subsequent determining of DFS on family size decision making and family planning involvement, the qualitative data further seeks to explain how varying socio-economic and cultural factors impact on married men and women in

the dynamic rural setting of Western Kenya with the intention of learning why DFS differs when viewed quantitatively.

Knowledge of family planning methods is another measure used to indicate fertility regulation potential among respondents in quantitative studies such as the DHS. It is expected that respondents who are aware of the methods available to regulate their fertility are in a better position to do so, especially when these methods are accessible and the individuals have positive attitudes towards fertility regulation and family size limitation. While the "autonomy" of family planning knowledge in influencing individuals' fertility behavior has been contested because of reported inconsistencies between the variables of knowledge and contraceptive use reported widely in DHS data, pursuing an accurate perception of this facet will yield a more comprehensive understanding of its connection to fertility regulation.

In the DHS, the knowledge questions ask both male and female respondents if they know of any means a couple could use to regulate or stop child bearing. The questioning goes further to find out whether the respondent is aware of a modern method of family planning, or only traditional methods. The concept of "knowledge" is, as a result, reduced to "awareness" of at least one modern method of family planning, or any traditional methods. Measuring knowledge with these limitations reduces its potential significance in addressing this study's goals. Some researchers have pointed out an underlying ignorance of any technical understanding of specific modern methods, a fact that inhibits either the beginning of contraceptive use, or enhances contraceptive use discontinuation fueled by the rumors that surround these methods within a community. Technical knowledge of contraceptives while significant for contraceptive use or at least its

continuation amidst the existence of myths and rumors is not examined in questions that only relate to awareness.

In this study, spousal knowledge, fertility preferences, and approval of family planning are examined and related to their reported communication while checking for variations in age, education, parity, sex preference, and composition. This study does not limit knowledge to contraceptives awareness, however. Qualitative data is collected that relates not only to whether or not husbands and wives are aware of contraceptives and their attitudes about contraceptive use, but how they develop perceptions of family planning for their own application. While a fixed definition of family planning is often assumed in quantitative studies (contraceptive use by women or sometimes men in either limiting the number of children they have, or spacing their births), the qualitative data relates to how spouses interact with their socio-cultural, political, and economic backgrounds to create meanings for their own fertility regulation involvement. It is when we understand how they conceptualize family planning for themselves that we can make sense of the various paths taken by husbands and wives in seeking to get involved, get their spouse involved, or not get involved in contraceptive use at different times.

Qualitative Data

Focus Group Discussions

The study employed Focus Group Discussions (FGDs) as its primary investigative technique in collecting qualitative data. A FGD is a qualitative research technique frequently utilised in social science research to obtain the information on “why questions” that is missed in closed and open-

ended survey questionnaires (Ochola-Ayayo, 1989). According to Morgan (1988) in Macun and Posel (1998:115), FGDs are typically defined as bringing together a small group of people to participate in a planned discussion on a defined topic, with the aim of producing data and insights from the group interaction. The nature of the FGDs allows the respondents to talk freely and spontaneously about the themes covered in the study, and others that arose.

A lot of planning for the focus groups was done (across a three week period) before the actual holding of the various group interviews for this study. Various factors went into the planning in terms of determining the realization of the actual numbers of groups to be held, group formation, number of participants, sources for the participants for the various discussions, and the actual interview sites for carrying out the FGDs.

My entry point into this area that was already familiar to me at the time was to introduce myself and the study to various participating gatekeepers. I reported to the District Commissioners' office, and presented them with a copy of the proposal and the research clearance permit I had acquired from the office of the President in Nairobi. I obtained an official map of the district from the relevant authorities, and physically visited the various district divisions. I also procured a local headman in each division that could take me around the area as well as act as an invaluable source of information in regard to residential area set-ups, household locations, visits to the available local clinics, local trade centers, and figuring out the logistics involved in carrying out the group discussion. Practical logistics included possible locations and travel distances for the participants and my research team, as well as expectations in terms of time

compensation and travel expenses. Once I had a working understanding of the area in relation to the study, I took time to re-examine my plans, keeping in mind my research goals.

Focus Group Discussion Areas and Selection of Participants

Given that this study sought to examine spouses across the district, the decision was made to use administrative boundaries to get a cross-section of participants. As a result, two FGDs were planned for husbands, and two for their wives for each of the three divisions in the district. The general similarity between the socio-economic statuses of the divisions was noted, and emphasis was not placed on establishing different sets of participants, but rather on having a sample of participants that was spread out across the district.

Twelve FGDs were held for the 62 male participants and 56 female participants (wives of the men involved in the FGDs). Of the wives of the men who had participated, six were unavailable at the time of their respective group discussions. The qualifying factors for study participants included marital status, residence in the area of study, and age. The marital status and residence criterion were to ensure that all the study participants were married at the time of the study.

Participants of the FGDs were between 20 and 54 years old. These were considered locally to be childbearing ages, and it was expected these participants would be the best targets for providing insights through the arranged discussions. While this study does not have a representative sample, it does examine experiences and perspectives through group interaction concentrating on

"those population segments that are going to provide the most meaningful information" (Axelrod, 1975b: 10 in Morgan 1988:43).

In determining a strategy for selection of participants based on age, we recognized the possibility that older and younger participants may have difficulty communicating with one another, given that they may have different experiences or that the cultural consideration for older people may affect the level of the discussion's openness. Effort was made to bring together people who would otherwise not have a problem having open discussions about their reproductive health experiences. Age was categorized into younger (ages 20 to 29), middle-aged (ages 30 to 39) and older (ages 40 to 49) participants.

In order to accommodate for the age criterion, of the two FGDs held in each division, one was comprised of older and middle-aged participants, while the other was comprised of younger and middle-aged participants. This allowed for a variation within each group, achieved by mixing age groups while specifically keeping the youngest and oldest age groups separate. As a result of this planning, comfortable environment enhancing open discussion was achieved and approved by local study participants and headmen.

In total, two FGDs were conducted for husbands in the Vihiga division (one for older and middle-aged, and the other for younger and middle-aged participants). Two FGDs were conducted in the Luanda division and two in the Tiriki division—each with the same age set-up. The same was done for the women's FGDs. In the rest of this document, references are made to

Vihiga, Luanda, and Tiriki divisions as study areas, while further descriptions identify the participants' age groups and family size references.

Determining the Size of the Groups

In determining the size of the groups, I took into consideration the size of the research team that was available, and decided on a range of participants between eight and twelve. This choice was supported by past experience as both manageable and effective in enhancing group interaction with the involvement of all participants without leaving anyone out. In each area, twelve participants were targeted—bearing in mind the possibility that some participants might back out at the last minute. Due to various logistical and personal issues, a few participants failed to turn up, and as a result the figures sometimes changed from one group to the next.

Actual Selection and Invitations

The first task was to identify men who qualified, and then find out from them and from their wives if they would be willing to participate. We ran the risk of getting a negative answer from either of the spouses, and no decision was made before hand about how to treat such a response, should it occur. We took a "wait and see" approach, and watched to see if a positive or negative response would be the norm. It would be interesting in further studies to examine the most effective approach to see if more respondents could be procured through different contact techniques. We later found that unwillingness to participate was not going to be a major factor. The main reason initially targeted individuals dropped had more to do with the unavailability of the spouse. This happened in six cases in total.

The actual selection of participants was done by myself, with the assistance of local administration officers, mainly the chiefs from the various locations included in the study. The chief provided a headman, who then gave me with a verbal description of the area and its residential arrangements. With the headmen as guides, we traveled through the divisions, then opted to hand-pick households, making sure that we spread them out, and marked them as targets—taking into consideration that the chances of these targets being relatives would be minimal given the residential distances between them. Having done this, we went to the homesteads and sought out one male participant that fit the age and marital status criterion. Most of the time the men we approached were not available at that time, and we would go back at a time indicated by the other homestead members. The unavailability of the target person would lead us to continue on to the nearest homestead and continue with the invitation process. The whole process from invitation to acceptance for all the participants took about a week in each of the local areas.

Background Characteristics of Study Samples

Below is a table showing some of the background characteristics of both the KDHS and FGD samples.

Table 1

Sample Characteristics of Husbands and Wives in the KDHS and FGD Samples

CHARACTERISTIC	KDHS SAMPLE				FGD SAMPLE			
	WIVES		HUSBANDS		WIVES		HUSBANDS	
AGE	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
15-19	17	9.7%	11	6.3%	9	16.1%	6	9.7%
20-24	32	18.2%	26	14.8%	17	30.3%	15	24.2%
25-29	40	22.7%	36	20.5%	15	26.8%	10	16.1%
30-34	30	17.0%	30	17.0%	9	16.1%	18	29.0%
35-39	30	17.0%	31	17.6%	5	8.9%	9	14.5%
40-44	17	9.7%	17	9.7%	1	1.8%	3	4.8%
45-49	10	5.7%	25	14.2%			1	1.6%
Total	**176**	**100%**	**176**	**100%**	**56**	**100%**	**62**	**100%**
EDUCATION	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
No Education	23	13.1%	7	4.0%	5	8.9%	3	4.8%
Primary	98	55.7%	86	48.9%	40	71.4%	38	61.3%
Secondary	52	29.5%	81	46.0%	9	16.1%	19	30.6%
Higher	3	1.7%	2	1.1%	2	3.6%	2	3.2%
Total	**176**	**100%**	**176**	**100%**	**56**	**100%**	**62**	**100%**

OCCUPATION	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Not working	74	42%			9	16.0%		
Proff. Tech. Manage.	7	4.02	18	10.23	2	3.6	2	3.2%
Clerical	3	1.72	7	3.98			2	3.2 %
Sales, small scale trader	22	12.64	15	8.52	13	23.2%	14	22.6%
Agriculture	64	36.78	101	57.39	29	51.8%	24	38.7%
Household and domestic	1	0.57	7	3.98				
Skilled manual	3	1.72	12	6.82	1	1.8%	18	29%
Unskilled manual			15	8.52	3	5.4	2	3.2
MISSING	**2**	**1.1%**						
Total	**176**	**100%**			**56**	**100%**	**62**	**100%**
CURRENT FAMILY SIZE	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
0	9	5.1%	8	4.5%				
1	20	11.4%	13	7.4%	5	8.9%	3	4.8%
2	33	18.8%	28	15.9%	7	12.5%	7	11.3%
3	23	13.1%	23	13.1%	10	17.9%	9	14.5%
4	23	13.1%	18	10.2%	13	23.2%	17	27.4%
5	23	13.1%	25	14.2%	10	17.9%	12	19.4%
6	14	8.0%	13	7.4%	5	8.9%	6	9.7%
7	11	6.3%	15	8.5%	3	5.4%	5	8.1%

8	12	6.8%	15	8.5%	3	5.4%	3	4.8%
9	5	2.8%	4	2.3%				
10+	3	1.7%	14	8.0%				
Total	**176**	**100%**	**176**	**100%**	**56**	**100%**	**62**	**100%**

The above table presents some of the background characteristics for the husbands and wives, both in the KDHS sample and the FGDs conducted in the Vihiga district. The purpose of the table is to present a clear picture of the respondents and participants used the samples in this study, however, the comparisons between the two samples are limited largely by their sampling process. The KDHS generally involved a wider area and included a random sampling of the whole of Western Province, while the FGDs concentrated on specifically selected divisions within the province, as explained earlier. The two samples are also different in terms of size. The KDHS includes a total of 176 wives, and 176 husbands, while the FGD sample encompassed 62 husbands and 56 wives. Although these discrepancies make it difficult to engage in a valid comparison, we can seek to examine the different samples based on the specific background characteristics presented.

The KDHS sample of 176 couples involved a wide selection of participants in terms of age. The mean age of the women in the KDHS sample is 30.55. The youngest age is 17, and the oldest is 49—with a range of 32 years between them. The KDHS men's sample has a mean of 37.0. The youngest age is 20, while the oldest is 54—with a range of 34 years between them. The standard deviation for women was 8.1, and for men 8.9, respectively. Both groups present a wide variation of participants aged between 17 and 49 for wives, and 20 and 54 for husbands. The

majority of the respondents were, however, between 20 to 39 years, while the 25 to 29 presented the highest specific age group of both respondent genders.

The selection of FGD participants was based on 10-year age groups[4], and not 5 year age groups as provided by the KDHS. The FGDs participants were categorized into three age groups as mentioned before—younger, middle-aged, and older represented by participants between 20 to 29, 30 to 39, and 40+. The FGD sample had a majority of participants in the 20 to 34 age range, with the 25 to 29 group having the highest number of wives, and the 30 to 34 group having the highest number of husbands.

An examination of the educational characteristics between the KDHS and FGD samples reveals that the majority of participants in both samples have at least some primary school education. The KDHS sample, however, has higher percentages of both husbands and wives with secondary education when compared to the FGD participants, as well as a slightly higher percentage of respondents with no education when compared to the FGD participants. In both samples, however, husbands had higher representation in the secondary school category than their wives.

The mean numbers of children for spouses in the KDHS sample are 3.94 and 4.87, respectively. While 5.1% of wives and 4.5% of husbands had no children, the maximum number of children reported was ten, and nineteen for wives and husbands, respectively. The standard deviation of 2.94 among number of children as provided by wives, and 3.41 as provided by husbands reveals some variation between the numbers of children reported by either group.

[4] (the FGD participants have been re-grouped into 5-year age groups in this table to allow for comparison with KDHS participants)

The majority of participants in both the KDHS samples and FGDs had between two and five children. While at least 58% of wives and 53.4% of husbands in the KDHS sample reported having between 2 and 5 children, these figures increase to 71.5% and 72.6% among the FGD spouses. As a result, the FGD samples are less varied when compared to the KDHS sample in terms of current family size. Given that the respective FGD samples represented much less than half of the KDHS participants, and considering the purposive selection of participants for the FGD samples, this difference can be expected.

Differences were noted in both samples between spousal reports on family size. The FGD participants attributed the discrepancy to children born before marriage, or the husband having children with someone other than the wife while married. This phenomenon was referred to by study participants as “outgrowing”. While respondents explained that this was fairly common in the area, they agreed that it was on the decline, especially due to difficult economic conditions, the high costs of educating children, and the fear of getting HIV.

Occupation as a characteristic in both samples reveals that a high percentage of respondents identified themselves as agricultural workers. However, a considerable figure (42% of wives in the KDHS sample) reported not working, while this figure is reduced to 16.0% among the FGD sample. The collective nature of the FGD data could influence participants to mention similar occupations, especially agricultural, because most of the homes in the area engage in some form of farming, even if it’s small scale or seasonal. The skilled manual occupations which formed the second most common category among the FGD male participants included carpentry, mechanics,

brick-making, and driving. The unskilled occupations included stone-breaking, occasional labor in the local tea factory, and public transport vehicles assistant (locally known as “manamba”).

The Research Team

The research team was selected to efficiently serve the FGD collection method. All members of the research team had experience in handling data collection by FGD, and were from the local areas. We had two moderators—myself, and a male moderator—both with previous training and experience in FGDs at the post-graduate level. We chose to utilize both a male and a female moderator in case male participants felt uncomfortable speaking in front of a female moderator. While a pilot focus group had not raised any alarms, it was still considered wise to have a male group moderator in case the issue arose. The team also had two pairs of note-takers, one female pair and one male pair. There were six members of the research team in total. Although the note-takers were recruited from the University of Nairobi, they also came from the local areas. I ensured that all members of the research team could relate to the study areas in terms of languages spoken, but would not be familiar with the study participants personally.

Training

While all the members of the research team were previously trained and experienced FGD researchers, a brief group-training was arranged to make sure that we were all clear about how the groups were to be handled, and create a connection between the team members and the study at hand. The training involved reviewing the tasks of each of the members, revisiting the FGD

guide, and having mock group discussions to enhance the researchers' understanding and confidence while running the FGDs to ensure the quality of the data collected.

The Moderators

This study employed a previously prepared guide for the men's and women's FGDs. The guides incorporated the study objectives, and specifically prepared to interact with the male and female participants.

The role of the moderators during the FGD was to use the discussion guide to keep the session focused, while at the same time allowing for open and continuous interaction between the participants. For each group discussion, the moderator introduced the discussion topics and sought to engage the participants in an enthusiastic and lively rapport. In the beginning the moderators introduced the "house rule" that only one participant could speak at a time. This would allow the note-taker to keep credible notes, and assist in the tape recording of the sessions—the main method of collection. The moderator then introduced the study guide questions, while allowing participants to get into discussions about the various themes.

Other factors that the moderators took into consideration were leading the group, rather than being led by it; allow for flexibility in focusing on the themes in the discussion guide; and making room for related themes that were not covered in the guides. Moderators also typically enhanced the verbal communication between participants while avoiding gestures and expressions of personal prejudice, and listened carefully to effectively guide the discussions.

While the significance of building rapport with the participants and being flexible to additional suggestions was pointed out, the challenge lay in doing all this while at the same time guiding the discussion away from one to one interviewing of participants towards a more engaging group discussion where the participants were communicating among themselves to a point that they would forget the presence of the moderator. The moderators observed the participants' non-verbal communication, and responded accordingly. For example, if there were any indications of fatigue, or boredom, they would suggest a break.

The Note-Takers

Each group discussion employed two note-takers—one taking notes, while the other recorded the discussions on the tape recorder. It was the note-takers' responsibility to record the date, time, and location of the meeting; the number of participants and their descriptive data including sex, age, and occupation. As the discussions were carried out, the note-takers also provided a general description of group dynamics, including the level of participation, whether there was a particularly dominant participant and how they were contained, and the general interest level of the group—including whether they seemed enthusiastic, impatient, or bored.

In addition to the descriptive data, the note-takers also recorded participants' discussion contributions to supplement to the tape recording. These hand-written notes proved significant in terms of clarification and insight through personal observations. The note-takers used quotation marks to indicate participants' own words, while personal observations and impressions were written in parentheses.

The note-takers also functioned as co-moderators—providing assistance if the moderator missed comments made by a participant while listening to another. The co-moderator could also point out to the moderator any questions missed during the discussions, and help the moderator resolve any internal conflicts between discussants.

FGD Setting and Process

The FGDs were normally conducted within the compound of the local health clinics or hospitals. Each FGD had between eight and twelve participants who sat in a semicircle facing the facilitator and note-takers. Everyone present had a complete view of everyone else, allowing participants to communicate with each other while giving the note-takers and facilitator full view of the group dynamics.

The FGDs were conducted in the local language, and all participants and facilitators—including the researcher—were comfortable speakers of the language. The results were then translated into English and transcribed. Language translation proved to be difficult in some incidences, mainly when there was no translation for particular phrases. However, the fact that we all spoke the local language assured the closest fit in English while certain expressions have been left in the local language with explanations given in English.

The note-takers used previously agreed upon coding in identifying the participants. The participants were coded in a clockwise direction (R1, R2, R3 etc. from left to right). These codes

were linked with the names of the participants so that the research team could easily identify names at short notice.

The whole team (the research assistants and I), would meet soon after each FGD. The notes were validated and consolidated as the tape played through for the whole team to give their input regarding the results. All this was promptly recorded—an exercise that proved not only convenient, but essential for the continued and final data analysis. These responses addressed critical elements like mood, emotional reactions to various questions, extent of agreement and disagreement of various opinions both verbally and by the nodding or shaking of heads.

Before examining the various strengths and weakness of FGDs encountered in the current study, I note the general difficulty in carrying out research in the study area largely due to an existing research fatigue among the adult population. This is the result of numerous and frequent projects carried out in the area, partly because of its high population rates and the presence of various social development organizations. Some potential study participants were skeptical, citing that many studies have been conducted without adequate feedback or clear gains to the local population in terms of new development projects. The local population has also been widely exposed to the concept of compensation for research participation, in forms ranging from monetary to commodity (such as sugar) compensation. The study participants had high expectations for compensation, and some specifically expressed a preference for monetary compensation. This proved impossible to achieve, given the tight budget we were operating under, and the participants had to settle for lesser compensation in way of food and refreshments.

Strengths and Weaknesses of the FGDs

In the fieldwork for this study, the FGDs proved most suitable and adaptable to the respondents and myself. They helped limit the phenomenon of the interviewer as an "outsider" seeking sensitive information. The group environment helps to ease the intensity of the interviews, enabling more open presentations of opinions. Macun and Posel (1998) allude to the potential strength of the FGD technique and its capacity to redistribute power in the research relationship between the interviewer and the participants.

Marshall (1995) contends that FGDs avoid the artificiality of the one-on-one interview. Since they are socially oriented, FGDs facilitate the study of participants in a more natural, real-life atmosphere that gives the facilitator the flexibility to explore unanticipated issues as they arise in the discussion. The interaction between participants offered by focus groups as a data collection tool proved invaluable for the research by providing the opportunity for researchers to allow participants to interact in relation to study questions, yielding rich insights and sometimes bringing forth themes that had not been fully considered before hand. This enabled the collection of valuable data, whose sensitive nature may not have been captured by other forms of data collection like one-to-one interviewing.

Invaluable in research of socio-cultural dynamics and their effects on behavior, the flexible nature of the FGDs allow the exploration of unexpected issues such as how contraceptive use related to violence against wives; the social stigmatization of vasectomy; rigid definitions of family planning that further impact on fertility discussion, decision making, and contraceptive

use. Other advantages of FGDs include their relative low cost and quick results covering wide sample sizes.

In utilizing the FGD strategy, I made sure that none of the respondents in a particular FGD were from the same extended family, or related by marriage. This was done with the help of the village headmen, who knew everyone in their village. The groups were also made up of people who share common attributes, in this case gender and relative age, education, and status. These elements worked to create an environment of openness, and a feeling of equity among the participants.

Although the FGD was clearly an essential tool for qualitative data collection in the study, allowing for the collection of data across a wide range of respondents over a relatively short period of time, FGDs also have their limitations.

Despite the obvious uses that the FGDs served for this study, the method in general has been criticized as producing an un-natural setting for the collection of valuable interactive data (see Morgan, 1988). The potential negative nature of FGDs hinges on one of its strengths—the collection of a wide range of data from various groups of people at the same time. The possibility of both vocal and ideational dominance does exist among individuals engaging in a group discussion, —a possibility that did not go unnoticed in the execution of this study. In the first FGD, we witnessed two outspoken members exercising an ability to take over the discussion. The situation was handled expertly by the experienced research team who made sure that every

participant had the opportunity to speak. The use of FGDs in this study assisted in the creation of a permissive environment, which in turn encouraged the expression of differing opinions and points of view.

The FGDs proved to be a complex method of data collection, highly dependent on the skills of both the researchers, and the study participants. Dealing with a quiet group of people at the formal beginning of a session that increasingly turns into a highly-charged discussion, irrespective of time limitations, requires both talent and resolve. The “creation of order” within an essentially chaotic environment was a privilege, as well as a challenge.

The Conceptual Link and Operationalization of Concepts

As mentioned earlier, this study employs a political economic framework incorporating the concepts of level, process, causality or individual agency, time, and methodology as significant in examining and providing further insights into spousal understanding of fertility regulation, and their family planning communication.

While this study’s conceptual framework focuses on the significance of examining multiple levels of society, the quantitative variables mainly provide data at the individual level. The knowledge and attitude variables, for example, provide individual spousal knowledge and approval of family planning. In order to achieve couple level data, the methodology employed uses a couple data file and bivariate analysis to relate each individual variable to that of the

spouse. The quantitative variables are cross-examined to explore comparisons between husbands and wives. Making use of data that can provide information on specific couples allows us to further examine the differences between the knowledge, attitudes, and preferences of spouses regarding family planning.

To fulfill the study conceptual framework and further address the objectives, focus group participants' reports on family planning approval, knowledge, and various notions or motivations of family planning are further examined in relation to processes at various levels including local, community, and national levels. Thus, the notions of family planning promoted at these levels, and how individual husbands and wives relate to them when forming their own attitudes, knowledge, and motivations for family planning involvement are examined in the FGD data analyses.

While this study underlines the significance of all levels of information, including global, national, local, individual, and couple levels, the data is limited in providing specific findings on the individual and couple levels. A comprehension of fertility regulation at other levels such as the local and national are applied in analyzing the data as provided by the existing literature. Some levels of influence revealed in the current study include husbands and wives as individuals; spouses initiating communication and contraceptive use or non-use at the spousal level; male and female FGD participants and their relation to other male and female social networks; local community levels as reported by study participants in terms of the role of local leadership, local service providers, and popular notions of family planning involvement either reported or observed in the local community; national level as enhanced by national family

planning programs and reports by FGD participants of the roles of mass media including radio, bill boards and how individuals interact with these and other processes in the formation of motivations for contraceptive use or various strategies for family planning involvement.

Drawn from individual, couple, local, or national level understandings of family planning, the current study applies the concept of levels to the examination of specific variables. Knowledge, attitudes, preferences, intentions for contraceptive use, and couple family planning communication are examined for variations at the different contextual levels.

Looking at causality, the KDHS data is limited by the cross-sectional data. While it associates contraceptive use with the prevailing knowledge, attitudes, and communication, it cannot provide causality or fully describe how any of these variables influence the others. While complex statistical analyses can, to some extent, achieve this with larger data sets, the data employed here is limited when applied to issues of causality. The KDHS data is also limited in terms of providing explanations for differences in behavior, especially between individuals that share similar structural contexts such as age, education, occupation, and income.

In seeking to address causality as provided in the contextual framework, the FGD data as used in the current study provides insights into how spouses interact with different contextual environments in forming varying understandings of family planning and spousal communication strategies for the realization of fertility goals. The different factors that husbands and wives take into consideration, the different motivations, individual agency in interacting with these factors, limitations in this regard, and specific significance at varied times in marital and reproductive

histories is the second aspect of causality that is well provided for by the FGDs in the current study. The nature of the FGD provides participants with the opportunity to explain their knowledge, attitudes, fertility preferences, and contraceptive use intentions—revealing insights into their individual perceptions and varying motivations for family planning involvement.

Spousal agency is revealed in the revelation of the participants' self-perceptions of their fertility knowledge; reports on involvement in various information and attitude formation circles by way of social networks; varying application of factors that are promoted at the local level as enhancing motivation for contraceptive use and their interaction with these in forming motivations for family planning involvement are some of the factors that the FGD findings reveal in terms of individual agency.

In relation to communication, individual agency can be seen in the spouses' choice of different communication strategies, the timing of these strategies, and their nature and outcomes. These findings are also examined for factors that influence individual agency in gender relationships, or socio-cultural set-ups and the success or failure of their fertility goals.

The concept of process is one aspect of the culture and political economic framework that is least applicable by the KDHS data. The quantitative methods of data collection in line with conventional approaches to examining fertility behavior do not provide room for unique interaction between individuals and groups and these processes, and as a result offers limited explanations of results in terms of contraceptive use or non-use.

The FGD data, on the other hand, is more easily applied to the concept of process because it provides the opportunity for participants to provide details of their knowledge, attitudes, preferences, and motivations; explain their fertility behavior; and for the researcher to examine these details in relation to various national, local, individual, and couple level processes.

The processes influencing the different levels of knowledge, attitudes, and spousal communication such as the influence of social networks, mass media communication, local service providers, economic factors such as land resource and social and economic implications, husband and wife provider roles, aspiration for children's education, locally held perceptions regarding the health of the mother and baby, and contraceptive use are some of the factors that are examined in relation to motivations for family planning at the couple level.

Looking at the concept of time, The KDHS data provides knowledge, attitudes, preferences, intentions, and communication regarding contraceptive use in terms of timing. The "current use" data provides no opportunity to examine previous or even future notions, which makes it difficult to understand the related reports on contraceptive use. The "ever use" data provides some indication of both current and previous use, but does not link the contraceptive use or knowledge and approval of family planning to any specific timing practices.

The FGD data is examined for aspects of time both in perceptions of family planning and spousal communication. For spousal understanding of family planning, this study relates specific findings on approval, knowledge, notions held, contraceptive use intentions, and communication strategies and outcomes to the marital and reproductive history of participants, and examining

the differences or changes as they appear at different stages. This is achieved by comparing younger and older participants, and their family sizes. The categories of initial family size, incomplete family size, and near completed or completed family size are employed as identification of the timing aspects. Participants reference to previously held notions are also noted in clarifying changes in understandings of family planning and unique social, cultural, political-economic processes noted.

Reports of spousal family planning communication are examined and further organized into categories based on the nature of the communication; the timings of various discussion types in relation to age, marital, and reproductive history; and the outcomes that result.

As seen in the examination of all the concepts above and how they are applied in this study, the use of both quantitative and qualitative methodologies allows us to apply the various concepts of the conceptual framework. While not all of the concepts can be adequately covered by both methods, the combination of KDHS and FGD data in this study enhances the use of the culture and political-economic framework in addressing the study's objectives. The KDHS data provides a reliable picture of knowledge, attitudes, preferences, intentions, and spousal family planning communication in the local area, while the FGDs provide an understanding of the nature of the gaps in the KDHS data.

Definition of Terms[5]

Family size definitions, as used in the current study, apply to both the number of children and—to some extent—perceptions held by the participants about this. Instead of the small, medium, and large family sizes often used in demographic studies, the current study uses the terms initial, incomplete, and completed or near completed family sizes.

Initial Family Size

Initial family size in this study refers to what participants explained as the first few children. This is often two children, or one for a few participants. The term indicates the participants' perceptions that they had only begun bearing children, with the expectation that they would bear more in the future.

Incomplete Family Size

Incomplete family size can be related to "medium family size". Participants in this case had what they perceived to be a considerable family size, though they considered themselves as not having completed their child bearing. The majority of these participants also had children of both sexes, usually totaling up to four children. They looked forward to having a few more children, usually at least two.

[5] This applies to the terms used in this study in relation to participants' family size and timing in reproductive history. The terms are coined from details provided by study participants whose discussions were carried out in the local language. I am aware of language variations in the translation of details, but the translation and description of these terms aimed to provide descriptions that were close to the participants' presentations thus are not conventional presentations of the notion of family size, however the translation was verified by other local language speakers.

Completed or Near Complete Family Size

Both the terms “completed” or “near completed” family size refer to what participants perceived as a family size that is at its end stage. The use of the term near complete together with completed family size in the current study relates to the fact that the majority of participants who considered themselves as having completed child bearing sometimes used the term “near completed” instead of or together with “completed”. Reasons for this can be related to the absence of conscious action, such as contraceptive use, even though they had achieved or surpassed their desired family size. The various reasons surrounding this are examined in the data analysis.

Quantitative Data Analysis

The quantitative data from the KDHS is analyzed using the SPSS (Statistical Package for Social Scientists) computer software. Frequency tables, cross-tabulation, and correlation are all employed in the presentation and analysis of the data. While frequency tables reveal relevant individual characteristics of husbands and wives, cross-tabulation is done to reveal further information on the couples specifically. Agreements and disagreements between partners reporting on specific issues can be identified, providing opportunities to examine relationships between discrepancies and family planning involvement. Apart from spousal comparisons, this data is further examined in relation to respondents’ education levels and ages.

While this study could have employed multiple regression analysis to analyze the significance of the variables in the observed relationships, the number of cases in the study was too small for an

effective multiple regression analyses. The total number of respondent couples for Western Province is 176 and missing values for some of the variables further rule out the possibility of a successful regression analysis.

A bivariate correlation analysis, while it does not enable the examination of all variables together, it does allow us to observe the direction and strength of relationships between the variables. A cross-tabulation of specific variables regarding both husbands and wives with each other provides us with valuable information for answering this study's research questions. Trends of agreement and disagreement about family planning approval, fertility preference, desire for more children, and communication between couples are identified. Understanding the disparities between spouses and their influence on reproductive behavior outcomes enables us to observe partner influence in reproductive health decision-making. The quantitative analysis is complemented by its integration with the qualitative data collected during the FGDs. Furthermore, the quantitative analysis is further complemented by its integration with the qualitative data collected mainly using Focus Group Discussions.

The SAS Statistical program

While the SPSS program was initially used for quantitative data analysis, the SAS computer software was used in further data analysis. The switch to the SAS program is a result of the unavailability of the SPSS at the time of analysis. The two programs serve the same purpose, however, and the KDHS data sets provide files for the specific use of each program.

The Kappa Measure of Agreement

The kappa test measures the presence and level of agreement between two independent ratings. The upper limit of the kappa coefficient is +1 (which implies total agreement), while the lower limit lies between 0 and -1. A kappa coefficient is equal to 1 when there is complete agreement of the rates.

While controversy surrounds the use of kappa in actually quantifying levels of agreement, the kappa statistics are appropriate for testing whether agreement exceeds chance levels for binary and nominal variable ratings. The kappa test reveals the proportion of agreement after chance has been excluded.

The test is specifically applicable to the data and objectives of this study whereby husbands' and wives' reports on variables are compared and examined for further insights. The fact that the same categories are used for both genders' responses makes the data in this study specifically applicable for the kappa test. The kappa statistic in this study is used to examine agreement between spousal reports on use of contraceptives, approval of family planning, and family planning discussion. The kappa analysis allows us to examine agreement in the responses once the chance agreement has been removed. It provides us with clear interpretation of the cross-tabulation findings. A low kappa indicator for spousal reports on communication, for example, indicates wide differences between husbands and wives reports about family planning communication when those who have similar answers by chance are eliminated.

For the current study, differences between spousal reports on fertility behaviour serve to underline the complexity of couples' family planning involvement and the need to further examine family planning perceptions, processes, and implications for fertility behaviour by husbands and wives.

The conceptual framework of this study underlines the need to examine the couple not simply as a single unit with joint understanding of family planning and similar contraceptive use intentions, but as husband and wife who may experience the prevailing structures and processes related to family planning differently. The significance of the role of individual agency for husband and wife as presented in the conceptual framework suggests varying implications in terms of their sources of family planning information, various interactions, diverse perceived implications of contraceptive use for their spouse and family, varying understandings of family planning, and contraceptive use intentions. The kappa index is therefore significant for this study as it allows us begin to see these differences between husbands and wives when we compare their responses to questions on their family planning behaviours. Findings obtained from the cross-tabulations and kappa test are also related to qualitative findings to provide insights into the differences in reporting of family planning by husbands and wives and their family planning communication processes.

The Chi Square

This is a measure of association used for nominal and ordinal data. The Chi square reveals statistical significance that allows us to conclude the existence or non existence of a systematic

relationship between two variables. In this study, 0.05 is the level of statistical significance, and a 95% level of confidence is applied.

Chi square is used here to examine individual spousal reports on family planning discussions and their relationship with selected background variables. This further enhances our understanding of the family planning discussion variable.

The Pearson's Product Moment Correlation Coefficient

This is a measure of association used to evaluate the strength and direction of the relationship between the two variables. It indicates whether the relationship is positive, or negative with values ranging from +1 to -1 with 0 indicating no observed association. In this study, the pearson's coefficient is used to examine the association between spousal approval of family planning, their reports on fertility discussions, and background characteristics and variables.

Focus Group Discussion Data Analysis

As Neumann (1997) noted, qualitative analysis does not provide the operational advantages identified with quantitative data analysis. It involves a researcher's reflections in the examination, sorting, categorizing, evaluating, comparing, synthesizing, and contemplating of data. The data, however, is expressed and presented in words, which are relatively imprecise, diffuse, and context-based (see Neumann, 1997:427). Despite all the 'mess' that might be associated with qualitative data, the challenge lies in the creation of order both conceptually, and structurally to provide an explanation and understanding of the various themes under study.

The FGDs in this study were tape-recorded in the Kiswahili language, with detailed notes taken in English and data transcribed verbatim. As is common with qualitative research, analysis began in the field with the continuous identification of various emerging concepts and the examination of evidence related to the study objectives. A data reduction process aided the interpretation by organizing the data into conceptual categories, creating and specifying themes and concepts. This enabled deeper insight into the data, and recognition of various patterns related to specific themes. An examination of the initial codes enabled the organizing and reflection of the themes while providing an understanding of key concepts in the analysis.

Incorporating Qualitative and Quantitative Data

Objective 1: To examine spousal perceptions of the concept of family planning, as well as their motivations for involvement.

The quantitative data from the 1998 KDHS is used to compare the knowledge of and attitudes towards family planning, fertility, child-sex preferences, and intention for contraceptive use exercised by husbands as opposed to wives. This study examines these factors at the couple level to provide a better understanding of spousal family planning perceptions and how they translate into contraceptive use or non use.

The qualitative data resulting from the FGDs enhances the analysis of this first objective by expanding the spectrum of elements to include contextual and subjective realities that work with the quantitative data to create a more comprehensive understanding of the study's objectives. The qualitative data resulting from the FGDs enhances the analysis of this first objective by further examining the husbands' and wives' understanding of family planning and its implications for family planning involvement. The focus here is to examine the concept of family planning as understood by both the husband and wife, and its significance on what reproductive behavior is adopted. Their understanding of family planning was therefore more thoroughly examined using qualitative mechanisms, the rationale being to examine various contextual realities, subjective perceptions, and understandings that inform married men and women about reproductive health behavior. Examining perceptions and understanding of family planning within contextual realities enables us to better understand the link between comprehension of family planning and the varying routes of involvement actually undertaken or sought out by married men and women. In so doing the question of partnership between married men and women in the enhancement of family planning and reproductive health is revisited for further development.

Objective 2: To examine the family planning communication process between spouses, and learn how it relates to contraceptive use.

The quantitative data makes use of selected variables from the DHS that seek to provide a picture of family planning communication and the variables that intervene. In this study, the

communication reported in the KDHS file by couples from Western Province is reviewed for agreements and disagreements, while noting any gaps presented in the quantitative data.

The qualitative data on spousal communication and decision-making seeks to examine the nature of various communication processes, their timing, and the contextual surroundings in addition to the simple presence or non presence of family planning discussions and choices. The data enables us to further understand communication and decision-making processes and the cultural, political-economic complexities that they encompasses, while examining the linkage to family planning and reproductive health enhancement.

The significance of using the quantitative KDHS data alongside the qualitative data is clear in its application to the political economic framework for this current study. While the KDHS data used in the current study cannot fully address all the complexities presented by the study's objectives, it remains useful in the application of the conceptual framework and the examination of the study objectives. The KDHS allows us to use a relatively large data set (compared to the FGDs), which provides a better representation of the participants and the population.

CHAPTER SIX

Husbands' and Wives' Understandings of Family Planning

Introduction

This chapter presents findings on the first study objective—examining spousal perceptions of the concept of family planning, and their motivations for involvement. Quantitative variables from the KDHS, examined, include husbands and wives' knowledge, approval, fertility preferences, and contraceptive use. In the analysis, this study treats these variables as factors surrounding the understanding of family planning developed by husbands and wives. These variables are examined for consistencies and inconsistencies between spouses and with the use of qualitative data further insights are provided regarding spousal understandings of family planning and implications for contraceptive use.

Spousal Knowledge of Contraceptive Methods

We begin by examining the KDHS findings on spousal knowledge about modern contraceptive methods. Couples data from 1998 KDHS on Western Province reveals high rates of both knowledge and approval of family planning. The study asked husbands and wives, separately, whether they knew of any contraceptive methods, and whether they could name any modern contraceptive methods.

Table 2

Comparing Spousal Knowledge of Modern Contraceptive Methods

	HUSBANDS		
WIVES	**Knows no method**	**Knows modern method**	**Total**
Knows no method	0 (0%)	0 (0%)	**0 (0%)**
Knows modern method	3 (1.7%; 100%)	173 (98.3%; 100%)	**176 (100%)**
Total	**3 (1.7%)**	**173 (98.3%)**	**176 (100%)**

This table above reveals that general knowledge of modern family planning methods is exceptionally high among both genders. Women unanimously report knowledge of modern family planning, while all but three men report knowing about modern methods as well. These findings fall in line with previous conclusions about knowledge in the study area, and in the country as a whole (see Fapohunda, and Rutenberg, 1999; NCPD and Macro International, 1999).

Given that the percentages reported by both husbands and wives are nearly unanimous, further examination of this variable incorporating background characteristics like age, education, and income is not employed. However, as noted in chapter four, the presentation of husbands and wives unanimously knowing of at least one modern contraceptive method does not tell us much about this knowledge's actual implications for contraceptive use. Spousal reports on contraceptive use are presented in Table 3.

Table 3

Comparing Spousal Reports on Ever-Use of Contraceptives

	HUSBANDS			
WIVES	**Never used**	**Used only traditional method**	**Used modern method**	Total
Never used	**45** (25.6%; 52.3%)	7 (4.0%; 36.84%)	11 (6.3%; 15.7%)	**63 (35.8%)**
Used only trad method	16 (9.1%; 18.6%)	**7** (4.0%; 36.84%)	6 (3.4%; 8.6%)	**29 (16.5%)**
Used modern method	25 (14.2%; 29.1%)	6 (2.8%; 26.3%)	**53** (30.1%; 75.7%)	**84 (47.7%)**
Total	**86 (48.9%)**	**20 (10.8%)**	**70 (39.8%)**	**176 (100%)**

The above table on contraceptive use reveals a wide difference between percentage (98%) of husbands and wives who knew of a modern contraceptive method, and those who had actually used a modern method. Less than 50% of wives and less than 40% of husbands had ever used modern contraceptives. The discrepancies between the figures in Tables 2 and 3 is particularly significant considering that the question asks not about current use of contraceptives, but ever use at any one time. This technically increases the potential for participants to answer affirmatively compared to if the question was limited to current contraceptive use.

According to Table 3, at least 25.6% of couples report never use, whilst least 30% report having used a modern method. On the other hand, at least 47% of wives report having used a

contraceptive method before, with 39.8% of husbands reporting the same. When combined, these findings reveal that at least 17% of wives who have ever used modern contraceptives have husbands who say they have never used one, or have only used a traditional method. In turn, at least 9.7% of husbands who report having used modern contraceptives before have wives who say they have never used one, or have only used a traditional method. In total, at least 41% of husbands and wives have spouses who report differently when asked about contraceptive use.

Different answers on ever use of modern methods by spouses in specific couples could be related to a husband's condom use with illicit or polygamous partners, or to secret contraception use by wife. Secret use of contraceptives can be related to individual agency as applied in the conceptual framework in this study. Wives who realize their husbands' negative attitude may decide to go out of their way to use contraceptive methods in secret in order to plan their family according to their own fertility goals. As noted in the conceptual framework, the spouses are not necessarily working towards similar family interests. However, the nature of the data above cannot confirm these, nor does it provide details regarding the circumstances surrounding ever use. This is further examined in the qualitative analysis.

When the level of agreement is examined, a simple kappa of 0.35 reveals poor agreement between spouses reporting contraceptive use. The 0.35 score is much lower that 0.70 to 1.0, which is the commonly applied criteria indicating satisfactory inter-rater reliability.

According to the kappa index analysis, the proportion of spouses whose reports on contraceptive use would agree after chance agreement has been eliminated is only 35:100. While Table 3

reveals that almost 60% of husbands and wives provide similar answers regarding their contraceptive use, the actual level of agreement is revealed to be very low once the chance agreement is removed. According to the kappa test for majority of couples, the spouses' report on ever use of contraceptives is not related to the partner' report especially when similar reports that only happen by chance are removed. The kappa test in this case serves to underline that most couples provide differing responses about their contraceptive use behavior. However, while the kappa data reveals poor agreement between spousal reports on contraceptive use, this study notes that this could be a result of poor question construction in DHS questionnaire. The question asks husbands and wives to say whether they had ever used a modern contraceptive method in the past, yet it does not ask the respondent to specify with which spouse the contraceptive method was used. The fact that some respondents could have been making reference to partners that were not in this sample could partly explain the varied spousal reports.

The disconnect between contraceptive knowledge and use can also be attributed to the influence of multiple levels, process issues, and individual agency as provided in the conceptual framework of this study. The KDHS data on knowledge reveals one aspect of family planning knowledge at the individual and couple levels as noted in the conceptual framework. The high awareness of contraceptive methods available indicated by both husbands and wives in the KDHS indicate a unanimity in knowledge of contraceptives at the individual and couple levels, but only as far as awareness of methods is concerned. The lesser figures of contraceptive use by the same respondents revealed a limited link between this level of knowledge, and contraceptive use.

Given that local and national family planning programs actively promote this widespread awareness, and often link it to the success of IEC fertility regulation programs, this elevated level of methods knowledge can also be related to the concept of process as noted in the conceptual framework—specifically the processes of family planning campaigns at the local and national levels. Yet individuals still employ their agency in the way they engage in contraceptive use including secret use, non use, or even condom use in extra-marital affairs. These factors are examined further using qualitative data in this chapter and the next.

Qualitative Data Findings on Knowledge

While knowledge of modern contraceptive methods does not imply their use, the use of qualitative research data provides insights into the nature of the knowledge held, despite the almost unanimous awareness of at least one modern contraceptive method. As in the quantitative data findings, all male and female FGD participants could name at least one modern method—the common being birth control pills.

While the possibility of some participants in a group setting simply repeating what they have heard from others is appreciated, the majority of the participants could at least make reference to the pill, while others mentioned injections, the coil, “permanent method” (tubal ligation), nor-plant, vasectomy, and condoms. The study notes that the condom, while it was commonly known by all the participants, was often mentioned last and usually as a result of probing. The implications of this in light of the documented efforts of HIV and AIDS prevention campaigns, is worth noting.

While both men and women revealed knowledge of various modern contraceptive methods, specifics were more readily presented in women's group discussions, than among the men. When asked about known methods, female participants more readily provided names either from their own use, knowledge of someone else's use, or exposure to the method through the local family planning clinic service providers. The majority of female participants reported having seen the pill and injection methods. These methods were mentioned by women across the age groups in all the FGDs. Other methods mentioned include the coil, the permanent method (also referred to as the "operation" method), and the nor-plant.

While older women also mentioned the pill, injection, and the coil, they were more prone than the younger participants to mention the permanent method without prompting. Women who readily mentioned the permanent methods tended to have a larger family size, and intended to complete their family size with the next child or two. Further probing, however, revealed that these women were not necessarily considering the use of the permanent method after the pending completion of family size, and that very few of those who indicated that they had a complete family size had actually undertaken the tubal ligation method. This supports the limited significance of the knowledge variables in terms of predicting contraceptive use (see also Fapohunda, 1998).

The coil, and nor-plant methods were also mentioned in all the discussion groups, however, after more prompting in some of the groups compared to the pill and injection methods. These methods were less readily mentioned without prompting in the Tiriki division. Again, participants from Tiriki pointed out that the methods were less commonly used in the area. Yet

the coil and nor-plant were, in comparison, relatively more known in Vihiga, based on readiness of participants to present them with less or no prompting.

The findings of the female FGDs reveal that when women were asked about the contraceptive methods they knew, they first presented methods that they had either seen, used, or discussed as opposed to simply knowing that a method existed. Their answers often contained extra information about how they knew with statements like, “I know the pills and the injection. I know several people who use the pills”, “I know the three-month injection, actually my neighbor was using the three-month injection”, or “The pills, everyone knows about the pills. Even young girls are using the pills before they get married.”

Husbands’ Knowledge and Perceptions of Knowledge

Men also presented relatively high knowledge of modern contraception in terms of knowing the various methods that are available, such as the pills, the injection method, tubal-ligation (referred to as “the permanent method for women”), the coil, and vasectomy. However, men’s limited knowledge of less popular methods such as the nor-plant and male vasectomy was noted. Similar to the women’s FGDs, among the male FGDs, statements regarding knowledge of the pill and injection dominated the discussions without probing. Statements such as, “I know modern contraceptive methods like the pill, many women use the pill” and “There is also the injection, I have heard about the injection” were very common in all the age groups. However, other common statements involved the coil and condoms, mainly among the young and middle-age

groups with incomplete family size from the Luanda and Vihiga divisions, “There is also the coil that they put in the woman” and “Today, the young men use the condoms as well, especially before they get married.” The permanent method was also mentioned, especially by middle-aged or older participants who were relatively more educated.

The FGD findings relate to the high level of knowledge reported by both husbands and wives in the quantitative findings presented earlier. This represents one level of family planning knowledge as defined in the conceptual framework—awareness of modern contraceptive methods.

This level of knowledge is important because it supports the presence of fertility regulation awareness, allowing family planning programs to conclude that local people do know that there are methods available if they want to space or limit their families.

Further FGD analysis reveals a variation in the participants’ perceptions of their own knowledge about family planning methods. More than 50 % of male participants in each group discussion explained that they felt their own perceptions regarding their knowledge of modern contraceptive methods were limited. These husbands expressed an overall lack of knowledge about modern contraceptives, despite having heard about them or been able to name them as seen above.

They did not feel that they knew much about any modern (female) contraceptive methods, and further probing revealed that even though they had heard about some methods such as the pill, many of these men had never actually seen the methods practiced and therefore did not consider

themselves knowledgeable. Many of these participants were younger and had not attained the number of children that they wanted. Relatively newly married with one or two children, they had heard about contraceptives before marriage, but had not seen any. Some middle-aged and older male participants, especially those whose wives were not using any method, also shared the perception that they were lacking in knowledge about modern contraceptives.

The quotes below are a few examples of participants who volunteered to explain that while they could name certain modern contraceptive methods, they did not perceive themselves as being knowledgeable about them.

> For me since I have never really seen those things, I really do not have an opinion about family planning. Okay I have heard about family planning, I know there is what they call the pills for women, but I really don't know details about the methods, so I really do not know them.

> I do not really consider myself knowledgeable about these contraceptive methods. Okay I know they are there, I know their names, but to tell the truth, it is difficult for me to explain how they work. I know they stop the woman from getting a baby, but that is all. I do not think I know much about the different methods. And today you know there are many methods it is not just the pills.

> I do not know much about the contraceptive methods. I just know them, some of them I can tell you, (their names) but I do not think I know much about them.

(Vihiga males, younger age group, initial family size from Tiriki, Luanda and Vihiga**)**

> I know we all say we know about modern contraceptive methods, but for me and I am sure for many men, we do not really know much about these methods. For example, this injection, how does it work? If you ask me, I do not know. Even what they call the coil, it is hard for us men, to know how these methods work.

> I cannot say I know about the contraceptive methods, apart from naming some of them. I really do not know them.

> It is difficult to say I really know the methods. I can not tell you how they work or anything else.

(Vihiga males, older group, near complete family size,Tiriki, Luanda and Vihiga)

> I can say that I know about the contraceptive methods like the pill, yes I know how they work, even the injection, there is one for two years another one for five years.

> The Female permanent method is where they permanently stop the woman from being able to conceive, and the male vasectomy, they operate on the man to stop his sperms so he cannot father a child. Yes I know somehow some of the methods.

(Vihiga District male participants, middle-aged more educated from Vihiga and Luanda)

Perceptions regarding limited knowledge were more common among older and younger male participants, particularly older males with less education. While middle aged participants also expressed limited knowledge, some participants in this age group also expressed confidence in their knowledge of contraceptive methods—generally the more educated males (having completed a secondary level of schooling) whose spouses were already using contraceptives. While there were younger participants who had also completed secondary education, they did not express similar confidence in their perceptions of contraceptive knowledge. This data points towards a combination of education and spousal use as influential on the knowledge of the husband. Exactly how these factors affect each other and, in turn, effect perceptions of male contraceptive knowledge cannot be determined by this study, and would be an interesting focus for future projects.

The husbands who perceived themselves as confident in their knowledge of modern contraceptives tended to reside in the Vihiga and Luanda areas, which are relatively more urban and physically closer to the district headquarters and public IEC programs than the Tiriki area.

An inclusion of information about female contraceptive methods in programs that seek to cater to male clients is suggested by the majority of male participants who perceive themselves as not being sufficiently knowledgeable of these methods. The implications for partnership, wives impressions on educating men about female methods, and contraceptive use are further explored in the chapter on couple partnership. The fact that the majority of male participants spontaneously provided these perceptions without being probed suggests that the perception of one's knowledge about modern contraceptives is indeed different from the definitions of

knowledge provided in the quantitative studies. The self perceptions regarding knowledge can be seen as another level of knowledge presented by FGD participants in this study.

Analysis in the chapter on couples' family planning communication reveals insights on how a man's perception of limited knowledge may influence spousal communication, negotiation, and contraceptive use between husbands and wives. The question of whether a husband's fertility regulation participation is boosted by further knowledge and understanding of how contraceptive methods work is vital to this study.

According to the qualitative data, there are two notions of knowledge—awareness of contraceptive methods, and self perception of knowledge. The latter involves individual agency and has the potential to provide a better relationship between knowledge and actual contraceptive use. However, while socio-economic factors such as age, education, and residence appear important, the data is limited at this stage, and unable to conclusively explain the relationship as it stands.

Examining Spousal Contraceptive Methods Knowledge

In both male and female FGDs, participants were asked to explain how the various contraceptive methods work. Apart from the fact that some contraceptives such as the coil, nor-plant, and the diaphragm are locally available but not widely known, many participants revealed a lack of technical knowledge about the modern contraceptive methods mentioned. Below are a few

examples of male and female participants' explanations. It is worthwhile to note the adherence to various myths and rumors regarding specific methods as well.

> I cannot say I know how they work, but it is hard to trust them (the methods). Like this they call the coil, I have heard that what it does is to remove any baby that may have been formed in the womb of the mother. So she ends up bleeding, and the baby is destroyed, that is not really good, because you never know what might happen to the mother when this happens again and again, it will have an effect on her health as well.

(Vihiga females from Vihiga division in middle age group and incomplete family size)

> I have heard many people say that especially when a woman has been using pills since she was younger, that is why when you marry her she cannot get children. Sometimes it takes a long time, sometimes not at all! So that is bad, that is why women should wait until they have been married and have children.

(Vihiga male participant from Tiriki division in middle age and incomplete family size)

While these examples are from relatively older or middle aged participants with incomplete primary education, a few men with secondary education expressed an enhanced perception as illustrated in the quote below.

> My wife is using the pills. She herself also works at the clinic, so she knows about them. I think the mistake many people do is not to go and get checked so that they

> can be given the right pills for their body. That is why you hear all these stories. But the pills themselves are not bad, my wife has been using them for a while now, we have four children and she is still using them.
>
> (Vihiga male from Vihiga division, in middle age with incomplete family size)

The participant above had a secondary education, and his wife had a similar education level. They also had professional occupations such as teaching or clerical positions in provincial administration. However, other educated, professional participants still alluded to poor quality of knowledge, suggesting that education alone cannot be conclusively related to the level of knowledge held.

Unlike the male group discussions where the perception of lacking in substantial knowledge about modern contraceptive methods was readily provided, this was only revealed among the female participants after probing. While the majority of participants were aware of the various contraceptive methods—largely the pill and injection—the quotes below reflect the female participants' perceptions regarding side effects, myths, and rumors. The pill, although a commonly known method in the area and most widely used, is surrounded by negative perceptions—the most common being that birth control pills cause secondary infertility. Participants from different age groups across the FGDs believed that the pills cause infertility especially if used early in life, and for a long time.

> Some people use the pill, but others say that it can cause infertility.

> I know someone who has failed to give birth after three years of marriage. They say it is because she started using the contraceptives when she was young.

(Vihiga female participants from Tiriki division from younger and older age groups)

> With the pills, some people say that they block the womb and destroy it so a woman cannot have babies again.

> Nowadays, young girls are using the pill, but especially when one starts when they are too young, they cause infertility.

(Vihiga female participants from Luanda division from younger and older age groups)

> The contraceptive methods are not bad, but you never know, it depends on your body. Sometimes your body reacts and they can affect you. They can even make you have complications when you want to get pregnant, but they are not necessarily bad.

> Sometimes someone may be taking expired pills, or something like that, so they of course can affect them really badly

(Vihiga female participants from Vihiga division from younger and older age groups)

Despite the lack of scientific evidence, local people connect the perceived increase of secondary infertility in the area to early use of the pill by young girls. The data also revealed a slight difference in the perceptions about contraceptive methods of participants in the Vihiga division.

In the FGDs held in Vihiga, while participants acknowledged negative perceptions regarding the pill and other contraceptive methods, there were some who attributed the trouble specifically to a method's expiration or to a difficult fit between an individual and a method, rather than as a result of contraception in general.

This suggests a more positive outlook towards technical knowledge of the methods, as well as a reluctance to place blame for negative effects solely on the method. It is interesting to note that the participants with these perceptions were largely found in the centers of Vihiga among the presence of a large hospital, two dispensaries, and multiple active family planning clinics.

The coil is another method that prompted uninformed notions regarding its mechanics. Some participants did not agree with the negative notions that other participants expressed about the coil, and pointed out the lack of technical understanding. It was mostly the younger and middle-aged participants that had never used the coil before that provided these negative impressions. Several of these participants reported fears that the coil brought about abortions, instead of preventing conception—reporting that they knew of someone who had conceived and given birth to a baby after what was perceived to be a failed-coil related abortion, and the infant had an impression of the coil on its the forehead. This information could not be validated, given that none of these women had actually seen such a child, so while reports of the coil having failed for certain women are accepted, this study notes the tendency of social networks to emphasize method failure with the spread of adverse information—like wide spread rumors regarding children born with impressions of the coil on their foreheads. Such rumors were not limited to

the coil. Others included reports of condoms getting sucked up into a woman's uterus and preventing future conception by creating a blockage.

These findings reveal that while women generally presented themselves as knowledgeable about modern contraceptive methods as noted in the earlier section, variations to this notion were exposed when asked about how well they understood the specific methods and factors surrounding various myths and rumors about the methods that prevailed locally. Many of the women who were not using any contraceptive methods at the time of the discussion could not differentiate between accepted side effects and myths or rumors. In some group discussions, arguments ensued between some of these women and those who were actually using the methods in question.

Perceptions that the **injection method** enhanced sexual desire was shared by the widest consensus among the female study participants—including women who were either using that contraceptive at the time of the study, or had used it in the past. Women who had not used the contraceptive said they had heard about the increased libido from a friend or a friend's friend who had used the method. Statements like, "I have heard that the injection increases need for sex," were common in younger age groups. Women who had actually used the method, however, were divided in regard to this notion, with some confirming it and others denying.

> The injection method is okay for preventing pregnancy, but it also increases sexual desire. Sometimes that is not good, because some husbands, when he sees

you always want sex, he starts suspecting you, that if he is not there you could have extra marital affairs. It can bring problems.

The Injection method is good, at least once you get it you forget about it until the three months have passed. But it is true that it increases the urge for sex. That is not bad, but sometimes it is difficult, let's say your husband is one who travels, what do you do?

(Vihiga female, younger group, initial family size, Tiriki, Luanda and Vihiga divisions)

I am using the injection, it is true, I think it increases ones need for sex, actually sometimes it is too much. I can say I have felt the difference.

I am using the injection, I am not sure that it increases the need for sex. I know that is what many people are saying, but I really have not felt what the others are saying. I have been doing well with the injection method.

I have used the injection before, I stopped because my husband said we needed to get more children, but I do not think it is a bad method. The goodness is you go to the clinic then they tell you when to go back. Apart from that, you do not have to worry about forgetting, like the pill. I really do not know why others are complaining, you will have sex with your husband even if you do not use the injection. Okay unless if you are not living with your husband or he is away for a long time, then that is a problem.

(Vihiga females, middle age, incomplete family, Tiriki, Luanda and Vihiga divisions).

On further probing to discover whether this perception was considered positive or negative, some of the women painted an essentially negative picture, noting that sometimes it was not possible to have sex every day or more, especially when one's husband was away or if he had the habit of coming home drunk, then the contraceptive created excess need. When asked why they had chosen the method, however, these women pointed to the influence of the health provider, but also cited the positive measures of the method, especially convenience and assurance of success.

While participants from all three local areas noted enhanced sex drive as a result of the injection method, there were participants who were using the injection who countered the view that the method enhanced sexual urge. It is unclear from this study whether this side effect is generally perceived, or actually experienced. Like actual use, residence and age were not clear factors differentiating participants holding the diverse views. However, younger participants in the FGD's more readily brought up the subject of increased sexual urges. It should be noted, however, that this may simply be related to a general readiness among younger people to talk about what may be considered "private" sexual matters.

In general, the injection method was presented by most participants as a viable contraceptive method option, particularly because one only needed to go to the clinic once every three months rather than worry about forgetting to take it daily like the pills. According to some participants, it was also a benefit that the injection method was not believed to have adverse effects on a woman's ability to conceive again.

> The injection really is a much better contraceptive even though some people say it affects the sexual urge. You see with the injection you also can get pregnant once you stop, it does not stop your fertility completely at the same time, you rest from having to like take the pills everyday, and you know you can forget to take them.

(Vihiga District female participant, middle age from Luanda division)

Given that the injection method is common in the area, partly because of the perceived convenience— visiting the clinic only once in three months and not running the risk of forgetting the pills or having one's husband throw the pills away for secret users or when they (husbands) had decided it was time to get the next child — what is clear at this point is that various factors come into play including specific method perceptions and individuals often have both negative and positive perceptions that may influence spousal communication, negotiation, and decision-making. It is necessary to explore how individuals and couples holding these types of negative perceptions about fertility regulation methods reconcile them with their approval of family planning.

The use of **condoms** as a contraceptive method also prompted mixed perceptions among the FGDs. We noted that it was usually the younger participants, both male and female, who mentioned the condom along with other contraceptive methods. When the method was mentioned, other participants (in this case slightly older and with larger family sizes) hastened to explain that condoms were seen as a contraceptive for men who were having extra-marital

affairs, either to assure that they didn't father illegitimate children or to protect themselves from contracting sexually transmitted diseases.

Although it was generally understood by both male and female FGDs that the condom is used to prevent pregnancy—a factor that is also revealed in the KDHS data—subtle perceptive differences were revealed when participants provided their own impressions regarding the use of condoms as a method of family planning. Older participants, particularly those with less education, indicated that condoms were primarily and practically not for family planning among married couples, but rather as a safety measure for men engaging in extra marital affairs. Some of the younger participants, on the other hand, had used condoms both before and in their marriages, but this group was significantly smaller.

This perception of the condom as being mainly for the prevention of sexually transmitted diseases can be attributed to the widespread public programs on reproductive health where the condom has been promoted as the main tool for fighting the spread of HIV and AIDS in the area. While condoms were available for fertility regulation and STD prevention before HIV and AIDS became prevalent, its promotion as the key in combating the spread of the AIDS virus has significantly altered the perceptions of the general population.

Vasectomy, known as the male permanent contraceptive method, was a hotly debated topic among the male study participants. Vasectomy was less readily mentioned as a contraceptive method in both male and female groups, but upon probing, the majority of men and women confirmed their knowledge of the operation. Interestingly, once the topic had been broached,

men readily volunteered their negative perceptions and revealed some of the social stigmas that surround the method.

> That permanent method for men (vasectomy) is not good. If I go for the permanent method, my wife can end up getting children with another man. It will mean that I do not want to get children with her, and I would have given her the reason to get other children from elsewhere. Actually, how would I even tell people this, they would say it is my fault!
>
> I have heard of that permanent method for men (vasectomy). The problem is that, they say once you get it done, you cannot perform sexually. It is very difficult for one to try that.
>
> That method (vasectomy) is a source of many problems in the home because it actually makes you to stop being a man in a sense. You cannot satisfy your wife sexually, you lose your manhood and you know that will mean that even in the house, your wife can start looking down upon you!
>
> (Vihiga male participants in middle and older age groups)

Widespread views about vasectomy in the local communities across the Tiriki, Luanda, and Vihiga divisions include perceptions linking it to both impotence and an inability to perform sexual intercourse. Study participants, especially older men, explained how a vasectomy suggested that the husband had forfeited his right to father children, leaving the woman justified

in having children with someone else. When asked specifically, some participants from the Vihiga division knew of men who had undergone vasectomy, despite the stigmas. None of the participants in the other divisions could allude to this. While this emphasis on the Vihiga division cannot be conclusive because the FGD sample was not statistically representative of the local communities, the Vihiga area—which houses a large number of civil servants working at the district headquarters —may house a larger population of men and women with higher educations and reduced stigma in terms of talking about vasectomy.

> Yes I have heard of someone who went for it (vasectomy), but it is only the wife who knows! (if he was negatively effected by vasectomy)
>
> There is a couple in our neighborhood. The wife says that the husband is still okay (after vasectomy), but still, how do we know? You think they would really tell everyone?

(Vihiga male participants from Vihiga division, middle aged with secondary education)

According to these quotes, having heard about someone who had undertaken a vasectomy did not necessarily improve the participants' negative perceptions. Most were quick to point out that such a man would not be quick to admit any sexual incompetence resulting from the operation. Results like this support the importance of a family planning program's responsibility to address these uniquely male concerns alongside the common focus on female fertility and reproductive issues.

Despite the fact that vasectomy was regarded so negatively, some participants expressed that they would consider vasectomy if the wife agreed and committed to keep it secret between the two of them. These participants did not necessarily believe that vasectomy had adverse effects on sexual performance, but still felt the need to keep it a secret so that they would not to be subjected to the social stigmas associated with the method. Details like this revealed that vasectomy was an unpopular method not only for people who believed the myths and stigmas attached, but for individuals who didn't believe these yet still feared what society would think.

In the case of vasectomy, a local program that provides accurate technical knowledge about what it entails and the real side effects associated with it, while addressing the myths would be appropriate. Such a program would be even more effective if it also promoted openness among men who have undergone a vasectomy and remain healthy both physically and sexually.

The need to involve the wife or sexual partners in such a program provides one area for the enhancement of partnership among spouses and partners by broadening the concept beyond engaging men only for the enhancement of contraceptive use and reproductive health for women, as is most common. Addressing men's contraceptive use and the sexual and social concerns raised in relation to vasectomy would be a step towards engaging men in family planning and reproductive health in their own right.

Limited Knowledge, Contraceptive Use Implications, and Sources of Information

Husbands and wives present different perceptions regarding the implication of limited knowledge (by men) on contraceptive use by their wives. While the majority of male participants, particularly the older men, did not make a connection between their own limited knowledge and its negative contraceptive use implications, some middle-aged men provided explanations of how a poor understanding of contraceptive methods hinders a man's ability to communicate and negotiate with his wife. The comments below illustrate how a man's limited knowledge makes his involvement in family planning difficult, making it hard to give their wife consent to use contraceptives when he has reservations about the methods, or does not perceive himself to be adequately informed about them.

> The problem is that many men actually do not know much about contraceptives. And for us men, when you do not know, then you cannot be sure that you want your wife to use these methods because many people have said different things about the contraceptive methods. So you have to be very careful, it is difficult to just ignore that.

> I have been refusing my wife to go for that injection. They say when one is on it then you are always tired and again the woman gets very sickly. I would not want that, who will take care of my children?

> Many men here do not know how these methods work, so they become very suspicious.
>
> (Vihiga males, younger and middle-aged, initial and incomplete family, Tiriki, Luanda and Vihiga)

The above quotes from male participants across the FGDs from middle-age groups indicate that the perception of being lacking in knowledge influenced the husbands, who in turn held back their wives from using modern contraceptive methods. Given that these participants were in their middle age and already had some children, they present the best scenario for contraceptive use by married couples as explained by the participants themselves, as shall be seen in the communication section. That is, they had already fulfilled their marriage with children. Reports of reluctance in allowing their wives to use a modern method due to poor perceptions of knowledge of the methods reveals a potentially significant impact that improvement of knowledge and understanding of how the modern contraceptive methods work would have on contraceptive use for couples who truly need it.

On the same note, however, other men in all the study areas indicated that they did not see how their lack of knowledge affected their decisions about their wives' use or non use of contraceptives.

> No I would not say it is because I do not have enough knowledge of the contraceptives, (reason why he refused the wife to use contraceptive method). I simply was not ready for her to use contraceptives.

> I do not think I know much about how the methods work, but I refused her to use only because I did not think it was right at that time.
>
> It is the woman who uses the method and they are told about it at the clinic. It is not my place to know exactly how it works. The clinic people do that with the woman.

(Vihiga male participants in middle age group from Tiriki, Luanda and Vihiga divisions)

The above quotes represent husbands who explained that their perceptions of lacking in knowledge about contraceptive methods does not necessarily impact on their decision making for their wives' use of contraceptives. As mentioned earlier, the majority of the men in all the discussion groups provided the opposite view. However for these men, all of who were in their middle age, this was not applicable. Factors that might explain their notion are not clear, yet both views had participants whose wives were yet to start using contraceptives, some due to their husbands' refusal. Thus the quotes above represent husbands who do not perceive their perceptions of lacking in contraceptive knowledge as affecting their decision making regarding contraceptive use, largely mentioning "not being ready" which can be translated to mean a small initial family size and confidence in the local clinic personnel. Yet the fact that they, too, had not yet accepted their wives' pleas for contraceptive use seems to limit the significance of this view.

The scenario described here whereby husbands' limited knowledge is perceived to be impacting negatively on their involvement in communication and decision-making provides some background understanding of the noted negativity in contraceptive use as displayed by some

husbands in the quantitative findings on low contraceptive use intentions as shall be seen in the section on approval below.

It is interesting to note that when asked about their opinion regarding men's knowledge, some women dismissed its significance, suggesting that such ignorance was normal and even expected.

> Many men do not know about contraceptive methods, unless maybe just condoms only. Yes, men know about the condoms because they use them nowadays especially the younger men. But when it comes to women's methods, not many men know much about them.
>
> Most men do not know much about family planning methods. They have heard about them, but they really do not know them, for example how they are used, like the pill.
>
> Most men really cannot tell how the modern contraceptive methods work. They have heard about them, but they mostly have negative attitudes about the methods and really do not know how they work.

(Vihiga females, younger age, incomplete family, Tiriki, Luanda and Vihiga divisions)

Other women presented the opinion that men were not only knowledgeable about modern contraceptive methods, but that this was perceived to be a better circumstance when compared to earlier times in the region.

> In my opinion, nowadays many people both women and men have come to know more about modern contraceptive methods. It is not like in earlier days when it was all negative.
>
> I think more and more men have come to know more about modern contraceptive methods.
>
> Men know about modern contraceptive methods as well. In our clinic there are now male community distributors, they talk to men and tell them about the methods even as they distribute condoms.
>
> In my area, our local CBD even though she is a woman she talks to men as well, especially if he is with the wife. So many men have come to get better knowledge of the contraceptive methods it is not just women who know them.

(Vihiga females, middle-aged, with incomplete family size from Luanda and Vihiga)

The women who believed that men had basic knowledge were mainly middle-aged, and could appreciate the fact that an understanding of modern contraceptive methods has improved. While the results are not clear cut, younger participants were quick to express men's lack of knowledge of modern contraceptive methods.

One explanation for this is that most participants base their answers on their own experiences with their husbands. The communication chapter will discuss how younger participants also had more difficulty when engaging in spousal family planning communication—a factor that may influence the wives' opinions regarding male contraceptive knowledge.

Apart from this, none of the participants who presented positive views regarding male contraceptive knowledge were from the Tiriki division of the study area. As noted earlier, Tiriki lags behind in what can be perceived as a socio-cultural transition, and many female participants underlined the traditional nature of men in the area. This could be linked to their further perceptions regarding limited knowledge of modern contraceptive methods as illustrated earlier. However, the line between negative attitudes and limited knowledge is not clearly defined in the FGD data. Some participants, when probed, seemed to exchange one for the other or use one to reinforce an explanation of the other. Quotes like, "you can know they do not have proper knowledge of the modern methods. You can tell from the fact that they do not like to hear anything about them" were common among this group of participants when asked why they thought that men have poor knowledge of modern contraceptive methods.

Several women expressed the need for men to know more about how various methods work, and were of the opinion that this would have a positive impact on both the adoption of contraceptive use, and its continuation. They felt that such a change would address the high rates of discontinuation attributed to husbands who insisted on getting the next child sooner rather than later, resulting in an unmet need for spacing for their wives.

Another group of wives however perceived their husbands' limited knowledge as vital to their continued secret use. They expressed that increasing their husbands' knowledge and involvement may, for some, pose a threat to their ability to continue using contraceptives. When asked about the implications of their own limited knowledge, wives revealed that their limited knowledge was perceived to affect their use intentions less when compared to husbands. The main reason given relates to wider opportunities for females to seek further knowledge and understanding and come into contact with successful users who help to down-play the surrounding myths and rumors and expand on the limited knowledge held.

> Like the pill, many people say that it will stop you from giving birth when you are ready. But my neighbor, her sister in law, she is using the pill and she now has two children, and she is younger than me as well, so I decided to try them.

> Yes, I had heard about that (that injection makes someone tired all the time), but my sister in law, she was also on the injection, and she told me she was just fine, she did not have any problem. Actually she is the one who made me to decide to go for it.

> For me, my local family planning mother (CBD), is the one who assured me that she was on the coil and if you look at her, she is fine! So I decided to try as well.

(Vihiga females in young, middle age and older age groups from Tiriki, Luanda and Vihiga divisions explain how they overcame the rumored side effects regarding contraceptive methods).

Many women, aware of the rumors and stigmas that surround certain methods, limit their communication with their husbands while they seek more information from reliable sources—like actual users or locally based service providers. The impact said rumors have on women as compared to men is one that requires further examination, especially in terms of decision-making. Rutenberg and Watkins' (1997) study revealed that women in the rural area of study express more confidence in non-program staff that are performing manual jobs in the clinics by directing questions about contraceptive methods to them. In Vihiga, findings suggest that informal social networks play a significant role in debunking the myths and rumors that surround the various methods.

Agency by the women as provided in the conceptual framework can be seen in the role of the social networks and different implications for contraceptive use motivation for husbands and wives. The agency exercised by female social networks serves to address the side effects and dispel the myths and rumors attached to contraceptive methods and enhance the agency on the part of the woman in forming intentions for contraceptive use. Both the conceptual framework and the study findings are limited in explaining the varied role of male social networks in addressing myths and rumors. Insights regarding this and other factors influencing couples' family planning communication are provided in the following chapter.

An examination of spousal reports reveals that while husbands and wives obtain contraceptive method information from various sources—friends, neighbors, the radio and other local multi media such as street advertisements—wives generally report interpersonal communication as a source of vital information. Wives are also more likely to receive information from the clinics they attend for pre and postnatal appointments in addition to a high incidence of information seeking and provision from close friends, third party friends (friend of a friend), sisters-in-law, neighbors, and local traditional birth attendants who double as community based contraceptive distributors.

While contraceptive use myths and rumors are inevitably spread by various social networks, women also report having received positive information that became instrumental in their decision-making regarding issues of contraceptive use—especially when such information was provided by individuals who had, themselves, undertaken contraceptive use.

The positive impact of a more personalized information network that is able to respond to and counter myths and rumors through direct interaction with modern contraceptive users as presented by various women study participants is underlined. The extent to which this influenced these women's readiness for contraceptive use expressed through higher intentions as compared to the intentions more common among the men is examined further in the section on motivations for contraceptive use in this chapter.

For a majority of the men, said information is received mainly from their wives or the local CBDs—most of whom are women—while men's own unique experiences with modern

contraception are often quite narrow. Men who have obtained higher education levels exercise an increased amount of work-related mobility, and tend to experience greater exposure to information imparted by mass media outlets such as radio, television, and public advertisements.

Despite these clearly limited opportunities for male engagement in a social network that advances their knowledge, news about unsuccessful contraceptive experiences or complications regarding particular modern methods seem to have no trouble passing quickly from individual to individual, and group to group. An environment conducive to indecision about contraceptive use approval—especially for this category of men, despite positive attitudes regarding family planning in general—can be understood within such a context.

The findings from the focus group participants reveal knowledge to be a relative experience, rather than a given (knowing or not knowing) as presented in the KDHS survey examination. This study identifies various levels of family planning or contraceptive knowledge, including what methods exist, what methods are available, the technical details of how particular methods work, an individual's personal perception of their own knowledge level, or their perception of the knowledge held by another individual.

These levels of knowledge can, in turn, be related to the contextual levels examined in the conceptual framework. The success of national and local family planning programs' IEC campaigns can be seen in the fact that both DHS and FGD participants could name at least one modern method of fertility control. Both the individual and couple level observations from the

FGDs reveal a gap in technical knowledge, and an overall negative bent to an individual's perceptions of their own knowledge, particularly among men.

Further exemplification of the political-economic framework is seen in the various processes (in this case represented by social networks) and mass media that impact on various aspects of knowledge held with social networks reported as having more significant implications in terms of contraceptive use motivations and dealing with myths and rumors for wives. Wives' agency is seen in their reports on significance of social networks including sisters'-in-law, friends and neighbors as playing important roles in enhancing their knowledge and their perceptions of adequacy of knowledge held. Husbands on the other hand rely more on previous education and mass media, communication processes that do little to answer or counter act the existing myths and rumors generally widely held in the local community.

Comparing Spousal Approval of Contraceptive Use

The Family Planning Approval or Attitudes about Family Planning variable has been used in studies to depict the potential for actual contraceptive use. The marketing of contraception unutilized by family planning programs in Kenya has focused on the enhancement of positive attitudes towards family planning. In the light of significant socio-economic change across traditional societies, family planning approval continued to rise throughout the country, with expected urban-rural differences (see Kekovole, 1998, Biddlecom and Fapohunda, 1998).

This study pays attention not only to male or female approval of family planning, as reported at the aggregate level, but also to the comparison of the approval that occurred specifically between respondents and their spouses. Table 4 provides a picture of the family planning approval of husbands in comparison to their wives, as noted by the KDHS data.

Table 4

Comparing Spousal Approval for Family Planning

	HUSBANDS			
WIVES	**Disapproves**	**Approves**	**Don't Know**	**Total**
Disapproves		8 (88.9%; 5.6%)	1 (11.1%; 3.0%)	**9 (5.1%)**
Approves	1 (0.6%; 100%)	133 (81.1%; 93.7%)	30 (18.3%; 90.9%)	**164 (93.2%)**
Don't Know		1 (33.3%; 0.7%)	2 (66.7%; 6.1%)	**3 (1.7%)**
Total	**1 (0.6%)**	**142 (80.7%)**	**33 (18.8%)**	**176 (100%)**

This data reveals a high approval of family planning on behalf of both husbands and wives, as outlined in previous studies (Kekovole, 1998, Biddlecom and Fapohunda, 1998; Becker, 1997; Chikamata, 1993, Ezeh, 1993) and noted in the literature review chapter. According to the couples' data, the majority of the couples in the study consisted of spouses who jointly approved of contraceptive use. At least 75.6% of the 176 couples had partners who both approved of contraceptive use according to self-reported data. While this suggests that most women have

husbands who report approval of contraceptive use, such reports have not proved to be indicative of actual contraceptive use between married couples.

Table 5 below shows how background variables like education, family size, and age all influence spousal approval of contraceptive use.

Table 5

The Significance of Background Factors in Spousal Approval of Contraceptive Use

Spearman's Rho (N)

	HUSBANDS	**WIVES**	
Age	.065	.062	**176**
Highest Year of education	.078	.003	**176**
Number of living children	.040	.005	**176**
Total children ever born	.078	.030	**176**
Spouse Approves	.461	.180	**176**

This study supplements previous findings by comparing spousal family planning approval at the couple level rather than just at the aggregate level. While a large percent of couples (75.6%) had both husband and wife who approved of family planning, when subjected to the kappa index test to examine the level of agreement between husbands and wives, the data revealed a simple kappa of 0.0480. This implies a poor level of agreement between spouses. According to the kappa

index analysis, the proportion of husbands and wives whose reports on family planning approval would concur after chance agreement has been eliminated is only 4.8 out of 100.

The low kappa index suggests that while approval of family planning may be high in the area, spouses do not necessarily hold similar attitudes about family planning. The low kappa index here begins to provide us with evidence that spouses do not necessarily have similar experiences of the concept of approval of family planning. According to the concept of levels in the culture and political economic framework as used in this study, attitudes of family planning can be of different levels apart from simply positive or negative. Husbands and wives allude to different levels of approval or disapproval and this can be related to their interactions with various processes of family planning communications and socio-cultural and economic factors presented at individual, community and couple levels. It is important to this study that the ways in which differing levels of approval affect a couple's communication processes be examined in further detail. This is done in the qualitative analysis.

Looking back at Table 4, at least 18.8% of husbands provided the answer "don't know" when asked if they approved of contraceptive use, while only one of their wives provided a similar answer. On the other hand, 18.3% of wives who approved of contraceptive use had husbands who said they did not know if they approve of contraceptive use or not. Previous studies have attributed this uncertainty to a fear of side effects or an allegiance to myths and rumors (Fapohunda and Rutenberg, 1999). As to why the men seem to exhibit more uncertainty than the women is a factor that is further examined using the qualitative data.

While the family planning approval variable has recently been widely regarded as almost unanimous for both women and men in Kenya (NCPD and Macro International, 2003, 1999), this study reveals that for at least 18.8% of Western Province couples, this unanimity does not apply. Generally, the ways in which spouses' contraceptive attitudes have been compared in the previous studies seems to reveal a more positive and unanimous picture than the ways husbands and wives within couples are examined and compared in this study. The significance of examining specific couples' family planning attitudes is that doing so provides further detail and indication of potential tensions in terms of contraceptive use, and would be important in the processes of intervention. While what is referred to in the conceptual framework applied here as structural causality factors such as the popularization of family planning by the media and family planning programs have readily increased positive attitudes within the local communities, agency and process at the individual level—such as the social networks utilized by women and men—reveals a variation in the approval variable. This is examined in the qualitative analysis.

Relating Husbands' Contraceptive Use Approval to Fertility Preference

The fertility preferences of husbands who reported an approval of family planning are examined in the table below.

Table 6

Husbands' Contraceptive Use Approval and Fertility Preference

	RESPONDENT APPROVES FP		
FERTILITY PREFERENCE	**Disapproves**	**Approves**	**Total**
Have another	1 (2.6%; 100%)	37 (97.4%; 26.1%)	**38 (26.6%)**
Undecided		70 (100%; 49.3%)	**70 (49.0%)**
No more		30 (100%; 21.1%)	**30 (21.0%)**
Sterilized		5 (100%; 3.5%)	**5 (3.5%)**
Total	**1 (0.7%)**	**142 (99.3%)**	**143 (100%)**

A majority (49.3%) of the husbands who approved of contraceptive use were also undecided about their fertility preferences. Fapohunda (1998) noted that understanding fertility preferences enables us to understand the existing demand for fertility and, consequently, its influence on family planning practices. This study shows that while contraceptive use approval and fertility preferences do not necessarily relate, this indication that many men share a high level of

indecision regarding fertility matters that their wives do not share presents questions as to how such partners overcome these differences.

Qualitative Findings on Family Planning Approval

In the FGDs, participants were asked how family planning was generally perceived in their local community, as well as their own individual attitudes about the subject. One of the intentions of the FGDs was to differentiate between different levels of approval and personal, and socially-motivated attitudes about fertility regulation, providing insights into the questions on "approval for who" and "approval why" (see Chikamata, 1996).

As in the quantitative findings, FGD participants expressed positive attitudes about family planning, referencing the change in the local community from previously negative attitudes to the current, highly positive ones.

> It has changed. Long time ago people used to get many children, but today they are using family planning more and more. They have known the problems that are there.

> More and more people are appreciating family planning, but it is still a difficult thing. Generally not everyone will accept to do or their wife to do family planning.

I can say yes, most people have changed, today more people have positive attitude about the importance of family planning, life is very difficult, and as we said earlier, family planning helps to be able to care for the children.

Today it is everywhere, even out there away from the clinic, it is on radio, so many people have been told about family planning, and many people today have come to accept it.

Family planning is more acceptable today, but that does not mean that many people are ready to use contraceptives, some people still refuse, it is a difficult thing.

People here have accepted family planning. Before, people, especially the men and older women were very negative, but nowadays attitudes have changed.

You know there was a time when women who used contraceptives were regarded as prostitutes, but that is not so much now.

Family planning is increasingly being accepted even by men, but some men just say they approve, but when you really check them out, do they really. Like my husband, he says he approves, but he will not allow me to

use, he says I must wait!

> At our village, people were so used to giving birth frequently but today you can see especially the younger women, the child gets to three years, even four for some people, before they get their next child.

> I feel that family planning is beginning to be really good. Mothers in law were really strict before, and would even chase you away if you were talking to the daughter in law about family planning, they say this one is pouring out our tea, she does not want my son's wife to get children! But today even the mothers in law are more understanding.

(Vihiga females, varied age groups, varied family size, Tiriki, Luanda and Vihiga divisions)

Both men and women from all three local areas, in varied age groups and with different family sizes explained that family planning approval had become more and more common in the local community. Women from middle-aged or older groups specifically described what they said were very negative attitudes in earlier times, and compared these to the more positive attitudes that persist today. Some participants, however, expressed the need for caution in declaring blanket approval. These participants brought up the fact that many men were not willing to allow their wives to use contraceptives, even though family planning approval had gained ground in the local communities. The female participants from Tiriki revealed the highest number of these types of concerns, while the participants from Vihiga were the most optimistic. The high

presence of family planning programs and HIV, AIDS, and IEC media in Vihiga and Luanda could account for both high approval of family planning and increased positive attitudes surrounding issues of family planning and reproductive health in the communities. Incidences of people expressing positive views in order to be in line with what is expected could also be a factor among the highly optimistic reports from various study participants in these areas.

Up until this point, the qualitative findings seem to be in line with the positive attitudes presented earlier in the quantitative data. The addition of the FGD data, however, introduces different levels of approval between husbands and wives.

While positive attitudes about family planning do tend to prevail in the local community, they cannot be said to be unanimous. Some participants, especially in the male FGDs, expressed clearly negative perceptions regarding modern contraceptive methods based on religious beliefs and health concerns. Some common comments spoken in the various FGDs were, “I personally do not accept family planning. I think it is wrong even according to God.”; “Using contraceptive methods is wrong it is messing up with the body. That is not how it was intended,” and “contraceptive methods mean that your wife may refuse to give birth, so why did you marry her?” While these comments do not represent the majority of participants, they do illustrate that in all the FGDs, attitudes about family planning were not inclusively positive. That negative attitudes about family planning still prevail both in the Vihiga division—which is more advanced socio-economically—and the Tiriki division (less advanced with stronger socio-cultural ties) suggests that adopting a positive outlook for all involved is both inaccurate, and ineffective.

The approval of family planning in the local community is related to what the locals describe as drastic changes in socio-economic situations throughout the area with high cost of living amidst unemployment, limited availability of land for families, high costs for education and health, and the general daily provision of the family. The widely held change in attitudes to positive perceptions of family planning in the local community is therefore explained largely in connection to increasingly difficult living conditions and socio-economic changes. Family planning is viewed as one way of addressing the situation.

The abundance of agricultural produce that used to form the core survival focus of the community is undermined today by land scarcity, the regulation of produce prices by national government, reduced prices for common crops such as tea and maize for local farmers, and delayed payment for cash crops by collecting cooperatives. Yet while only a small population can successfully engage in agricultural income, the whole population has been literally pushed into an economy where they require money to live—from food and clothing, to health care and education for their children. While noticeable efforts are made by both men and women to seek employment in return for much-needed cash, limited employment opportunities, even for the educated, makes basic subsistence difficult (see also Watkins, 2000; Bradley, 1995; Fergusson, 1992).

As a result, family planning at the community level is largely viewed not so much as an economic strategy in terms of parents ensuring a comfortable life for themselves and their children, but as a necessary means for coping with the harsh economic conditions that they find themselves in. In traditional communities where status and recognition are attached to family

size, such economic hardship is providing avenues whereby the community can begin to question the traditional desires;

> The population is so big yet we do not have enough food, no enough earnings, no job opportunities, life is especially hard for people who are parents today.

> As he said earlier, today family planning has been emphasized. It is good economic wise. The cost of living is very high. For example if you have two children in secondary school and two in primary it is very difficult!

> Now the idea of family planning we agree with it very much, mainly because of the way the economy is in the world. There is really no choice, you have to think about the children you are getting and how you will provide for them.

(Vihiga male participants from varied age groups, and having varied family size from Tiriki, Luanda and Vihiga divisions)

> Family planning is there and on my part I feel it is good. Because if we say that we shall look at the past, I think the economy has changed. In the past, children did not need education, food, clothes etc. Life has changed!

> Family planning is to stop people from living in problems, problems of educating their children, and generally caring for their children.
>
> Family planning is befitting nowadays because there is no employment.
> It makes possible the provision and care for children.

(Vihiga females from varied age groups, varied family size, Tiriki, Luanda and Vihiga)

In the above quotes, participants from various age groups describe the increased approval of family planning as being linked to a prevalently difficult economic environment. Both husbands and wives in different age groups and across the FGD areas commonly present this notion, which indicates how the understanding of family planning as one way of dealing with economic difficulty has become widespread. Notions of family planning as presented by focus group participants are related to local contextual environments including cultural, socio-economic, and political environments, as well as changes that have taken place in the community. An explanation and a justification of family planning at the local and community levels relates to various contextual factors that are seen to inform family planning perceptions and understandings at the local level.

Further probing of the participants revealed that other political-economic processes that have actively enhanced positive attitudes based on these background factors include national and local governmental and family planning programs with media messaging designed to link difficult economic situations to an increased need for family planning.

> That is true, today family planning has been emphasized. Even on the radio, you hear a lot about it, even in the village meetings. As a result, today many people are beginning to accept it family planning.
>
> The government has emphasized on family planning. They say it is good for the economy and we need to control the population.
>
> Today everybody talks about family planning, the local chiefs, even in the Churches they talk about family planning.

(Vihiga males from varied age groups, varied family size, Luanda and Vihiga divisions)

The local efforts of IEC are widely understood to have enhanced general family planning approval in the Vihiga and Luanda areas. Participants from Tiriki, however, tended to voice such opinions as a result of conscious probing. While local clinics in all the divisions have family planning programs, the visibility of media messages away from the clinics seemed more pronounced in Vihiga and Luanda, and less so in the Tiriki division. However, the general understanding of increased family planning approval was shared by participants from all divisions.

It is interesting to note that male participants in particular tended to drive the discussion towards what was commonly ‘accepted’ or expected within the local community, even when asked about personal perceptions regarding family planning approval. From the quotes above one can note a sense of a generalization in the answers provided. While this does not necessarily mean that

these participants were only trying to be politically correct, what it reveals is the locally publicized notion of approval for family planning in terms of dealing with the increasingly harsh economic conditions. Some participants kept mentioning the fact that 'family planning has today been approved here' even when asked about personal perceptions regarding family planning approval.

FGD participants revealed a general understanding of the changing conditions at the national level, alluding to the environmental context within which reproductive decisions were made in their parents' generation as compared to the current atmosphere. The community under study acknowledged and made reference to the fact that family planning had been a foreign idea that had been introduced earlier and generally met with negative sentiments from people. That the concept of modern contraceptive use as advocated by family planning programs and even the government had met with opposition among the community in general at an earlier time, any mention of its approval is often explained or even justified by the harsh economic conditions that currently prevail.

Watkins (2000), in her study of the neighboring region of Nyanza, noted that the harsh survival conditions that existed prior to colonialism, independence, and the advent of family planning programs is not recognized by the local community, despite various documentation—a fact that has resulted in a constant allusion to the need for family planning due to the harsh economic environment, and reductions in resource availability today.

Watkins (2000) refers to this as selective remembrance of the old generation that is responsible for building the picture of a previous past in abundance. However, what one may seek to understand at this point is how come there seems to be a stronger perceived and real link between the need for contraceptive use and resource limitations today more than ever, exemplified by participants consistent mention of 'harsh economic conditions today' as justification or explanation for their approval of family planning.

Apart from governmental roles in promoting positive family planning attitudes in the community, there are also local proponents—directly or indirectly linked to the local family planning programs—who have played significant roles in establishing the approval of family planning among community members. Locally based contraceptive distributors consist of local women, usually elderly and some of them previous or current birth attendants. The result is a group of women who are respected within their community who acknowledge and support the changing attitudes towards contraceptive use among both women and men.

While the majority of participants did not express negative attitudes per se, the FGDs did reveal the existence of twin perceptions of approval and disapproval held simultaneously by individual participants—mainly husbands who presented both positive and negative attitudes about family planning. This duality was commonly expressed with the phrase, "Family planning is good, but it is also bad. It is good because it enables one to have the children he can care for, but it is bad because…"

Various male participants in the current study make reference to family planning being good as it enables one to have the number of children he can take care of, and in the same breath point out

the ‘badness’ of family planning. The reasons presented as negative in view of family planning are two-fold. Firstly, that it is inapplicable and indeed problematic for the poor and secondly, that there might be negative effects of family planning—including the perception that it negatively affects the spousal relationship at the couple level and concerns regarding infertility issues and the various side effects of contraceptives on the user’s health. Thus as seen in the quotes below, these factors are still underlined even among male participants who approved of family planning.

From the qualitative findings what is important is not only the fact that some male participants oppose family planning as indeed this has been noted in previous studies, (NCPD and Macro International, 1999; Rono, 1998), but the various participants who hold the twin perceptions (the expressions of family planning as good and bad at the same time). The current study links the scenario of twin opposite perceptions to uncertainty amongst husbands as was presented by the quantitative data where 18.8% of husbands expressed that they did not know if they approved of family planning. Furthermore, some quantitative survey respondents answering in the affirmative to family planning approval questions may actually hold both positive and negative views yet, for various reasons, present only positive views in that instance—especially given that the question stops short of probing for further insights regarding family planning approval. As shall be seen in the section on motivations for family planning below, the qualitative findings reveal male participants as having commonly alluded to traditional values for children while expressing the modern perceptions regarding approval for family planning.

The current study also reveals that for many participants who had already alluded to approval of family planning, the economic reasons frequently provided as the justification for the use of modern contraceptives are not necessarily upheld. These participants underlined the hopelessness

of contraceptive use for purposes of addressing the hard economic situation. They expressed difficulty with the notion that their state of poverty would be affected by reducing their family size. For these participants, promoting contraceptive use to limit family size because of economic hardships sends a message that poor people ought not to have children—a perception that many individuals found insulting.

> Today yes, family planning has been stressed, and people are beginning to accept it. They say times are very difficult. But for me I do not think that it is okay. What do we mean, that people who have no money should not have children? How can that be?

> One cannot decide to take the position of God and tell people not to give birth. I think it is wrong! It is wrong when they start telling us that you should only have a certain number of children that is wrong! They cannot tell you the children to have, whether you are poor or not, the children are yours! How does one refuse to get children because they are poor? How do they know that those children would not bring blessings?

> You know when they say, stop after this last child, how does it help if you still do not have the money to provide for these other ones? In fact how do you know maybe the one who is to come after is the one that was going to become the President! And here you are stopping after say three children, and it is only the fifth or even seventh child that God has

> earmarked to be president. So if you are really poor, doing family planning can be meaningless.
>
> (Vihiga males, middle-age, incomplete family, Tiriki, Luanda and Vihiga divisions)

These individuals perceive themselves to be too poor to afford the services enhancing social mobility, such as an education, that other parents may be able to afford as a result of family planning. They underline that it makes no difference to them in terms of providing for their children, whether they have four or eight. Some previous studies (Oyosi, 1997; Mburugu, 1994) have shown that abject poverty may undermine the significance of family planning within a changing socio-economic environment. For parents whose poverty ensures that they or their children will have little chance for social mobility, there is little motivation for contraception and a tendency to find security in a larger family size. The concept of levels, individual agency, and varying understanding is therefore revealed in the FGD findings. While contraceptive use is justified at the community level mainly due to economic reasons, some male participants in the community, irrespective of their residence in the study areas, did not perceive this to apply to their specific situations of poverty. Apart from poverty, other factors that counted against family planning and informed participants with twin perceptions included various effects of contraceptive use either on the using spouse, or the couple's relationship as seen in the quotes below.

> Family planning is good, but it is also bad. Sometimes you see someone has only one child, not because they want to, and you can see, it is very difficult for them to accept this! And sometimes

contraceptives make a woman infertile, and you know the husband will be out there looking for another wife.

Yes today family planning has been accepted, it is important because of costs of children today. But it really depends on the person himself, because family planning also has its badness. Sometimes those methods can bring complications, and you find a woman can no longer give birth.

You know they usually say everything has its goodness and its badness. Now I really do not know if the advantages (of family planning) have become more or the disadvantages, but I think it is bad. The methods have negative effects on the woman, sometimes she becomes weak, and many other problems.

Family planning is also bad, depending on how you know your wife. If you have a wife whom will go out there, family planning will have given her the freedom to do that. But I am not saying it is bad only, because it is also good, at least you can avoid having too many children.

(Vihiga males, middle age, incomplete family, Tiriki, Luanda and Vihiga divisions)

The quotes above reveal various factors provided as explanations by male participants who held twin perceptions about family planning approval. What the study underlines here is the fact that, while family planning approval is generally high individuals and especially men continue to hold

concerns regarding their use. Specific commonly mentioned concerns that were presented by male participants included effect on child bearing ability or infertility, and increased physical weakness and frequent general illness and fatigue that impacted negatively on a woman's income generating activities and farming. The fact that these concerns about possible negative side-effects are similar between areas that are considered to have stronger traditional ties, such as Tiriki, and areas that are more linked to urban centers and have relatively higher incidence of family planning IEC media, such as Luanda and Vihiga, illustrates the importance of specifically addressing these concerns in the existing IEC media and establishing similar avenues for communication and education where they are lacking.

Looking at implications on the couples' relationships, both male and female participants from across the FGD sites expressed views that husbands widely believed that contraceptive use keeps the wife younger and also provided the freedom for extra marital affairs. The use of contraceptives by one's wife as expressed by many husbands in the study therefore could also mean increased incidences of conflict between the partners on grounds of suspected infidelity. These factors are further examined in the chapter on couple partnership and family planning decision making. The group discussion data therefore underlines the expressed conflicting views to family planning by some male participants unlike the almost unanimous picture presented by the quantitative findings at the aggregate level.

When approval of family planning is examined at the individual and couple levels, this study reveals more mixed sentiments unlike the clear community level approval previously presented. While approval of family planning is indeed held by majority in relation to general community

level approval, when participants begin to make presentations linked to themselves and potential options, they present negative sentiments alongside the positive approval of family planning. As seen above, approval for family planning for socio-economic reasons, while perceived as rational and embraced by the community for dealing with the changed contextual environment, may not be as obvious or practical as perceived by various participants in the current study.

This study further clarifies why, for many participants, contraceptive use may be generally approved of, but not actually embraced. Apart from harsh economic conditions and a perceived general understanding that family planning is indeed important for coping with the harsh environment, various other factors come into play when participants explained their involvement or intentions for family planning involvement amidst this environment. Economic conditions, irrespective of how significant they may seem in increasing people's approval of family planning, cannot in themselves account for individual contraceptive intentions. This illustrates the push and pull between structure and agency as noted in the concept of causality in the conceptual framework. Thus structural factors indeed play a significant role, in this case increasing positive perceptions of family planning especially at the community level. However, the individual in employing his or her own agency is further faced with variety of issues that may result in either negative or positive individually held perceptions and for the cases above, even dual perceptions held.

At this point however, the current study underlines the general environment of family planning promotion on various levels, including the community as seen above as well as the national and local governments and existing family planning programs—factors that help to enhance the

widespread understanding of family planning despite being limited in individual practical application. The fact that participants further related the association of harsh economic conditions and family planning approval with programs at the national and local levels is also suggestive of the role of the government and family planning programs in popularizing the link between the slim ability for families to progress and overpopulation and harsh economic conditions. Various participants therefore refer to family planning as “something that has come”, “something that the government has been emphasizing”, and “something that today, people are realizing the importance [of].” The implication is that positive modern change is fuelled by family planning. How far this has impacted on the currently generally held view that family planning would enable people to cope with the harsh economic conditions cannot be determined by the current study, yet it is clearly questioned by various participants speaking in relation to the poor in the community.

Twin Perceptions and Delay in Contraceptive Use

Focus group participants of both genders revealed high incidence of delay of contraceptive use by wives, even among those who were currently using a method. Women who were using contraceptives at the time of the study admitted that they had to wait for a long time after they had expressed a desire for contraceptive use before their husbands supported or encouraged them to do so. Said husbands indicated that while they approved of family planning it was, again, the prevalent fears of side effects coupled with myths and rumors that were responsible for the delay, as well as the aim to achieve a particular family size before engaging in contraceptive use;

> I am using the injection now, my husband used to refuse at first. He used to

say, ‘I will tell you’ (when to start). You see he wanted to get children first.

I am on the pill, but you know I had to wait for a long time. Actually I wanted to start right after my second child, but he would not hear of it, even though I told him it would be just for spacing. Now I have four children, two boys and two girls is when he told me, it was okay to use the pills.

I am not using any method, but we have talked about family planning with him (the husband). He says, ‘You have the children, then we can talk about family planning’, (that is when he will agree). He has been saying this for a while now. You see some men do not really understand that one will still give birth. He thinks if I use the methods then I may not be able to give birth again.

I have three children, two of them are girls. I know he wants me to have at least another boy before I can use contraceptives. He believes that if I use them now, I would be spoiling the chance of getting the next child.

You see for most men, even when he says he does not mind family planning, some of them do not really believe that they are safe, so he wants to make sure of the children, but he also knows that spacing is important. So what mine said is, let us space for now, but without the contraceptive. Actually for us it is God who spaced for us.

I take two years before I get another baby, so it is not too bad, it is okay.

(Vihiga females, middle age and older with incomplete family sizes, Tiriki, Luanda and Vihiga divisions)

I really do not have a problem with family planning. Today everybody agrees it is important. But my wife is not using contraceptives yet. You see, I want us to get at least some children, now how do I ask her to use contraceptives before that? What if something happens? You know some of these methods you never know what would happen!

Contraceptives are good, but there are many reports also that show women who get problems after using these methods. Some of them are always sickly, that is not good. For some even getting the next baby becomes a problem. So as the man you need to really think about this before your wife starts using these methods. And if she goes without telling me, then when she starts getting sick or has complications, she must not come to ask for money for the clinic!

I have the number that I want before she can start using these methods. Family planning does not mean you do not get children. We will use it after we get the children.

(Vihiga males, middle age, initial and incomplete family, Tiriki, Luanda and Vihiga)

The male participants quoted above, and others from the three study areas perceived themselves as approving of family planning, but preferring to delay the use of contraceptives in order to guard against what they perceived as possible negative effects that might inhibit their ability to obtain their desired family size. This is an example of when the concept of agency as highlighted in the conceptual framework seems to fail, especially in relation to women's needs. While some women may employ various strategies for the achievement of their own fertility goals, including getting more positive information from the available social networks, their actual use of contraceptives or its timing may still be dependent on the husband—whose suspicions and mistrust is fuelled by limited knowledge.

Table 7 relates husbands' indecision regarding family planning approval to their wives' reports on ever use of contraceptives.

Table 7

Wives' Ever Use of Any Method and Husbands' Family Planning Approval

	EVER USE OF ANY METHOD			
HUSBAND APPROVES FP	**Never Used**	**Used only traditional**	**Used modern method**	**Total**
Disapproves	26 (60.5%; 14.8%)	8 (18.6; 4.6%)	9 (20.9%; 5.1%)	**43 (24.4%)**
Approves	53 (42.7%; 30.1%)	12 (9.7%; 6.8%)	59 (47.6%; 33.5%)	**124 (70.5%)**
Don't Know	7 (77.8%; 4.0%)		2 (22.2%; 1.1%)	**9 (5.1%)**
Total	**86 (48.9%)**	**19 (11.2%)**	**70 (39.8%)**	**176 (100%)**

As Table 7 shows, only 47.6% of husbands who approved of family planning had wives who had ever used a modern contraceptive method. Given that the DHS question asks about “ever use”, this is bound to be a higher figure than current use of contraceptives, and provides a relatively more positive picture—although still low considering that 50% of wives who have never used contraceptives have husbands who say they approve of family planning.

The qualitative method of probing and discussion revealed elements limited by the quantitative survey questionnaire method. Thus positive answers to the question on approval in the survey fail to reveal elements of twin perceptions as discussed above that are considered especially when the husband is making reference to themselves or their wives’ contraceptive use.

Survey questions also do not capture the element of time that is captured in the qualitative findings in terms of relating contraceptive use or non-use to when the husband approved or did not approve. Qualitative findings reveal that even when husbands report approval, wives’ lack of contraceptive use can be related to husbands providing different communication of disapproval to wives, and this is related to factors specific to that time in their marital and reproductive history which explain the husband’s conveying negative attitudes while expressing general approval of family planning—which is exposed in the survey questionnaire format.

The study’s conceptual framework can be applied to the various levels of approval defined in the qualitative data. General community-wide approval is one notion that comes across as decidedly positive. A somewhat weaker level of approval is revealed especially by individual participants who, while noting the significance of family planning for socio-economic reasons, further note

its inapplicability to themselves as seen above. Thirdly, simultaneous positive and negative attitudes are enhanced for individual participants who hold positive attitudes about family planning on one hand, and negative distrust of specific methods and concerns about health risks on the other. While the details of the communication processes and decision-making in this regard are examined in the following chapter, in this section we underline the scenario for potential multiple results even in a context of family planning approval. Dodoo (1998) cautions that a high proportion of Kenyan men do want to limit family size, contrary to conventional wisdom that suggests that family size limitation is unpopular among Kenyan men. This study provides insight into why family size limitation would become popular, especially within an environment saturated with increased family planning approval on behalf of most husbands. It is noted that contraceptive use for limiting family size is related to delay in the start of contraceptive use and wives of these husbands initially experience unmet need for contraceptive use for spacing.

Local Contexts and Motivations for Family Planning for Husbands and Wives

While the various socio-economic and cultural factors that participants frequently presented as influential to their involvement in family planning have already been mentioned in the above sections on knowledge and approval, in the current section we examine how each of these factors helps to form notions of family planning as perceived by spouses in the study, and how husbands and wives interact with the various processes involved in these notions and impact on their own fertility regulation behavior.

The main focus for this section is to present the multiple realities introduced by key factors influencing fertility regulation behavior and variations between husbands and wives, translating these into their fertility regulation behavior. The notion of husband and wife agency within contextual processes and varying levels in understandings of family planning are underlined in this section.

Limited Land Availability and Contraceptive Use Motivations

Land scarcity has been revealed as the single most commonly referenced factor related to family planning as a means of addressing economic decline in the local community. Focus group participants of both genders explained the significance of the fact that most family land was too small for subsistence and no longer divisible for passing on to sons as inheritance in relation to fertility regulation perceptions.

Land is regarded as a key resource in economic and social terms in the Luhyia community, as well as in other agricultural societies in the country. Most families in the area live on pieces of land that have already undergone multiple subdivision for inheritance purposes, and the current generation of parents express their distress at being unable to fulfill this tradition further;

> Especially because there is no land, we people have no more land left, even the rich people have to go and buy land away from here now, so if you have only a small piece of land, and you get ten children today, what

are your children going to do!

In our father's time yes, they could have many children, but you know they also had something to give them.

You know before, we had land in this community. At least our fathers could inherit land from their parents, but that cannot happen today.

As parents today, we have to be careful. If you have too many children, and you do not have anything to give them, those children and your grandchildren will suffer when you are gone.

The children you give birth to can also be too much for you today. You may for example have only a small piece of land. So if you get many children, those children will start fighting and that becomes a big problem for the children. But if they are two or three or four, then it is easier to divide the land for them.

(Vihiga males, older, complete or almost complete family size, Tiriki, Luanda and Vihiga divisions)

Comparisons are made to previous generations who may not have been faced with a land problem of the same magnitude. While participants made reference to their "fathers" in this

regard, the term fathers may not have been used literally. This term was understood in this context to mean previous generations.

The increasing land scarcity has made it close to impossible for parents to live up to expectations of providing land inheritance for their sons. The community feels strongly about maintaining their traditions, and while it may seem to conflict when viewed one way, family planning is also perceived as a way of upholding the important social traditions. Less land is more easily divided between fewer sons, so spacing births and engaging in fertility regulation can, in this way, be perceived as maintaining the tradition of handing land down from father to son.

The influence of land issues on family planning matters was pointed out mainly by older men and women with large family sizes, or who perceived themselves as having reached completion or near fertility completion. Younger and middle-aged participants, however, even when acknowledging the significance of land availability, also noted that for many families land had long ceased to be viewed as an element of inheritance. These participants explained that they themselves or their friends had either not been able to inherit land from the parents, or were the one or two siblings out of several others who had actually remained behind on the family land while others had to establish themselves elsewhere. For the poorer families where buying land elsewhere was not an option, the extended family shared their parents' land. In such a scenario, the notion of family planning in the light of limited land availability loses significance.

Thus while scarcity of land is generally accepted to be a factor for family planning approval within the local community, this study underlines that this does not necessarily link it to a increased potential for contraceptive use—especially among the younger and middle-aged with smaller family sizes who expect to continue bearing children.

Inconsistent empirical evidence in previous studies linking land scarcity in agricultural communities to fertility decline (Clay and Vandaar, 1993; Robinson, 1992; Mburgu 1992; Boserup, 1989; 1985; Frank and McNicoll, 1987; Caldwell and Caldwell, 1987) also failed to provide adequate explanation to support the presence of such a link. According to the current study findings, the community makes significant reference to land scarcity in the same breath with the perceived need for embracing fertility regulation. However, family planning or fertility regulation is not necessarily seen as the answer, nor is land scarcity only viewed in economic terms as focused on in the previous demographic studies.

It is also important to note that the older participants, while providing strong statements linking land to local need for family planning, already have what may be termed as larger family size. One indication may relate to a notion of post facto rationalization, noted in previous studies, such as Fapohunda (1998) where participants relay this approval of family planning in connection to land scarcity in retrospect of their own reproductive activity and current family size in relation to the prevailing economic reality. As a result, this does not translate to contraceptive use intentions.

Children's Education

Part of the harsh, socio-economic conditions referred to by study participants when explaining their influence on family planning perceptions is the cost and perceived need for providing children with a formal education. The education of children is perceived to be significant for the social mobility of both the children, and their families. Previous studies suggest that the perception that children's education translates into old age security for parents, and acts as a motivation for parents to endeavor to meet the high education costs—in turn prompting increased approval of family planning (Mburugu, 1994; Kekovole, 1992; Knodel, and Wongsith, 1991). Other studies have pointed out that old age security need not depend on formal schooling alone. Parents with many children diversify the options for old age security by educating some and not others (Clay and Vander Haar, 1993). The fact that siblings also frequently educate one another has also been recognized to weaken the link between formal educational costs contraceptive use. Yet the significance of parental aspiration to their children's education on their approval of family planning is well-noted in the other studies (Oyosi, 1997; Mburugu, 1994). These aspirations can be seen in reports of families selling property such as cattle and even land in an effort to see their children through school, despite hardly surviving on these resources (see also Robinson, 1992).

The government has played a clear role in enhancing the value of education through policies and campaigns that have been enacted since independence—including free primary school education and monitoring of attendance by local administrations. This study further notes the localization of this notion of necessity of education. The expected economic payout from a child's education

is well-known in the community. This can be seen in the high number of urban-based relatives who, to a large extent, are responsible not only for the upkeep of relatives back home, but also for the general development of the local homes and the region in general (see also Ferguson, 1992). The prospect of "a better life" is expected for educated children by both their parents and the community in general. The decreased opportunities and subsequent frustration of unemployment, even for educated young people because of the national and local stagnation of economic growth have also been noted by study participants here and in previous studies (Bradley, 1997). While economic benefits have become uncertain, such doubt has not necessarily hampered parents' endeavors to get their children educated;

> Yes today there is a lot of emphasis on family planning. It is because,
> for example if you have two children in secondary school like me,
> and two in primary, and three have finished (secondary school),
> (then you really have no choice but to do family planning).

> Family planning is there. On my part I feel it is good. Because if we say we look at what was happening in our parents' time, I am thinking when this friend of mine was born, he was very lucky to have gone to school. Those days it was just giving birth, and giving birth. There was no issue of taking children to school.

> Okay, taking a child to school has become very expensive. We say we are working. If you take your child to school and he/she passes to go to

> secondary school, if you are not very careful you (and your family) may miss to eat in your home. Because you will find that that child has taken every single thing that you had in order to attend school. And you know you have other children after that one who all need to eat, go to school, they need medical care, for me, I think this is what makes life very expensive and family planning very important.
>
> (Vihiga males, middle age, from Tiriki, Luanda and Vihiga divisions)

Male parents in particular seem to present family planning as part of a strategy for enabling one to meet the costs of education for their children. While female participants also mentioned the costs of education when discussing family planning perceptions, the link between family planning and education was more readily presented by male study participants, especially those who were middle-aged and already had school-going children. A child's education is definitely significant for wives as well, however, considering that many described how some husbands leave the burden of taking care of children (including various school related costs) to their wives.

When the male participants' perceptions were related to their actual family planning involvement, the fertility regulation behavior ranged from delay of use (with the aim of achieving the "right" family size), to delay as the result of employing a strategy whereby one got a complete family size while he was still young so that he was better able to care for them, or delaying in order to ensure that they got the children they desired before exposure to the risk of infertility presented by the use of modern contraceptives. Thus while an aspiration for children's education does provide motivation for family planning involvement, there is the practical

existence of variation in contraceptive use intentions which can be related to the concepts of causality and agency as provided by the political economic framework in this study. Thus different participants employ varying strategies for family planning involvement despite the commonly held positive perception linking education to family planning at the community level.

Individual perceptions about the number of children one can take care of remain largely ambiguous when comparing gendered realities. The husbands examined refer specifically to the number of children they think they can afford to educate, delay in contraceptive use strategy. Wives on the other hand have to contemplate a varied set of issues and elements when considering how many children they can comfortably raise—including their own potential to earn income—and as a result may have different needs for contraceptive use.

Relating Family Planning to the Husband's Provider Role

Linked to the wide approval of family planning as a means of coping with the existing harsh economic environment in the community, various study participants explained their family planning involvement to relate to the number of children that they felt they could provide for. While both husbands and wives alluded to this significant factor in their considerations for family planning, the variability of this seemingly clear factor is revealed when we examine how individuals within the context of a couple relate this to their own family planning motivations.

Various husbands expressed that family planning for them meant being able to get the number of children that they could provide for. "Too many children" in this context was related to not just

the family size perse, as indicated by quantitative studies (high figures in relation to predetermined family size often in relation to the national average). Instead a high family size is described as that which the man shows obvious signs of not being able to take care of. Participants were usually not eager to provide a figure of what they termed to be “enough” children. Upon probing, this ranged from seven upward. Nevertheless, many participants explained that one has too many children when it is clear that he cannot provide for them.

Indications of failure include children who did not attend school, and children loitering in search of food from neighbors and well-wishers. This is seen as an indication that either the mother does not take good care of her children— especially in situations where the husband lives away—or that the husband is unable to provide for his own children.

The quotations below illustrate how participants refer to themselves in relation to family provision—revealing that the process is both individual and personal, especially when linked to the justification of family planning for economic reasons;

> You know with family planning, you have to think of how you are going to educate the children, your wife too may have her income, maybe from trading, but when your children cannot go to school, you as the man have failed! People will not say that your wife has failed, or even that you have both failed, it is you they will look at!

> You know now it is us (men) who suffer financially, so we must talk

about (and address) family planning from our perspective.

I think family planning is good, but I think it just depends on how your economic situation is. It depends on whether you can afford those children.

Family planning means that you make sure that you only get the children you can care for. That means when you feel they are enough, your wife needs to use the contraceptives so that she does not continue getting babies, otherwise they become too much for you.

It is the man who needs to make a decision based on how he is going to provide for these children, you have to think of school, even college for some children, you as the man. Yes your wife may help you, but these things affect you as the man.

But I think it is just that number that you feel you can take care of. So long as you know how you are going to provide for them, and you tell the mother (your wife) now close (stop) giving birth, stop at those ones that we already have, if they eat *sukuma* (type of local commonly consumed vegetables), if they will eat *mrenda* (another type of vegetables), let it be like that.

(Vihiga males, young and middle age, initial and incomplete family, Tiriki, Luanda and Vihiga divisions)

It is interesting that men in both the younger and middle-aged groups hold similar views regarding their roles in family provision and family planning. This perception that the husband ought to make important family planning decisions can be related to the fact that they are at a reproductive stage that features ongoing child-bearing, unlike older participants who have a relatively different gender relationship with their wives—factors that enhance the status of the woman in the home.

While the input of both husbands and wives in provision for the family is not necessarily in dispute, this scenario lends evidence to the understanding held in the current study's conceptual framework that family planning involvement motivation for husbands and wives involves not a joint understanding, but individuals within the couple interacting with their various contextual environments and forming family planning intentions related to the individual.

Male participants consistently related their perceptions of harsh economic conditions, unemployment, low earnings, lack of land to pass on to their sons for inheritance, high costs for educating children, and the quest for modern living to their own report about family planning involvement intentions. This poses a situation for conflict when related to wives who may draw from other understandings of family planning even while having economic justification as background of approval.

Male provision as mentioned by this group of participants mainly includes what are termed as "concrete" long term expenses such as school fees, housing, and big health care bills when

necessary. Previous studies in the area also revealed men to be commonly involved in these spheres of provision for their families (Robinson, 1992).

These participants' explanations reveal an acknowledgement of the women's role in family provision. However, they also reveal that they would rather refer to themselves when considering family planning involvement because, according to them, whether the wife is involved or not, they are "vested" with the responsibility to provide this kind of provision. They argue that failure to send one's children to school, for example, would be more readily blamed on the husband. On the other hand, unhealthy-looking children tend to bring blame on the wife. Even today, when socio-economic changes may seem to have diluted male-female roles within the family, definitions of success and failure still make reference to such gendered issues. Well-educated children are seen to be a positive reflection of the father (unless dead, or divorced from their mother), and healthy children are a reflection of their "hard working" mother.

Unlike the husbands who emphasized their perceived role as family provider, other husbands readily referred to their wives in relation to family provision. According to this study, this group of participants tended to be employed younger husbands with high school educations and wives with similar or slightly lower educations. Another factor that stood out for this group was limited interference from the man's parents due to residential relocation towards an urban center;

> I think family planning is good. Because when you get your first child, for us young men, employment has become so difficult to find. So once you get your first child, it is important to first rest for some years before

you get your next child. That is what my wife and I did. I felt that it was important for her to use contraceptives so that I could be able to financially manage the children we got.

I decided to ask my wife about family planning after our second child. I think family planning is good. Because when you get your first child, for us young men, employment has become so difficult to find. So once you get your first child, it is important to first rest for some years before you get your next child. Getting children in a hurry is not good. You can hurry them and find that you have given birth to too many children, and you find that you cannot provide for them, so I think it is good to do family planning.

(Vihiga District males, young, initial family, Luanda and Vihiga divisions)

These two men represent the aforementioned group. In the Tiriki FGDs, none of the male participants made reference to their wives' role in family provision, and further sought to down-play female involvement upon probing. One factor that sets the Tiriki participants apart is the fact that none of them reported living in a nucleated family.

The Female Provider Role

Like the majority of their husbands, female participants also mention the need to be able to provide for their children in reference to their intentions regarding contraceptive use. Family planning is seen by some women as one way of enabling them to contribute significantly to the

better provision of their children. A woman who does not strive to make a contribution to the family's economy is often considered "lazy" or "not clever" by fellow women.

Contraceptive use for women becomes the means by which they are able to free some time from household chores (that have no economic returns) so that they can engage in the outside economy and earn sorely-needed cash;

> I saw that it is me who was suffering with the children. He is not here all the time, it is me who has to be there, and it can be very difficult. You cannot do your own work, sometimes one is sick, then all are sick, then you have no one to help you, so you end up having very little time that you may at least go to the market and sell. I had to get clever, so I started using the injection. That way at least between my third born and fourth born there is three years, the rest were all in a hurry! And now I might stop there, he (the husband) does not seem to have a problem.

> Some men think that when the woman wants to use contraceptives then it means she wants to be naughty especially when you are young. But for most women, it is so that they can space their children and this frees them to carry on with at least getting some income.

> I have wanted to use contraceptives for a while now. I have three children, and I feel that we are going too fast. There is no one to help me with

> these children. Even my husband, you know when the children are all small it is the woman who feels the pinch. You cannot do much. You may want to do some trading, but this child is sick, that one needs your attention, now will you carry them all to the market?
>
> (Vihiga District females, middle age group from Tiriki, Luanda and Vihiga divisions)

These women, irrespective of their husbands' perceptions, consciously moved away from the depiction of the man as the only family provider. The limited ability of husbands to practically provide in the cash economy and the lack of some husbands' family responsibility were noted. For wives whose husbands were employed away from home, the irregularity of remittances was also mentioned.

The above examinations reveal how various husbands and wives who approve of family planning seek to relate this to their own individual circumstances and understandings of family planning—sometimes with widely varying intentions. While the relationship between education and family economic provision seem to draw majority men's involvement to focus on limiting family size, the emphasis on the relationship between family planning and the health of mothers and babies seems to relate wives more with contraceptive use for spacing births.

Maternal/Child Health and Motivations for Family Planning Involvement

Another major campaign slogan used by governmental programs to promote family planning portrays fertility regulation as essential for the health of the mother and child. Local family planning messages often feature images of responsible parents with healthy-looking families whose socio-economic and health needs are clearly well met.

Several participants in this study attributed reproductive problems to frequent births, and underlined the health of mother and child as a large part of the significance of family planning. Study participants, particularly women, voiced the perception that the community looked down on a woman who had children too close together—the suggestion being that such children suffered from inadequate breastfeeding and turned out to be weak and sickly while its small siblings and the one in the womb took their toll on the health of the mother.

The significance of spacing children is neither new nor unique to modern family planning programs (Lukalo, 1973). However, some "modernization" factors have prompted the reduction or demise of traditions like polygamy, formal employment for women, and an extended breast-feeding period which previously enhanced the spacing of children. The perceived need for contraceptive use to maintain child spacing and the health of the mother and children is even more important today than in the traditional set-up;

> You know this family planning as we were saying earlier it is important because it helps the mother's health, it helps the babies as well so it is important.

I think family planning is good, it helps the mother to get better and healthy after giving birth when she spaces the next birth.

It is also good for the children you see the children look healthy they are getting better feeding and care.

At our village, people were so used to giving birth frequently but today you can see especially the younger women, the child gets to three years, even four for some people, before they get their next child.

(Vihiga District female participants of middle age and older with incomplete family size from Tiriki, Luanda and Vihiga divisions)

I think family planning is good. It at least helps the health of the mother. Too many children sometimes also sometimes may drain the mother and she gets weak from giving birth so many times.

Family planning is sometimes very important. You may find a woman dies during childbirth because she is too weak. So she lives you with the young children, at least with family planning her health can be maintained. But not many people especially us men really recognize this.

Family planning also helps the health of the baby. When children are

> born again and again, the mother's body gets weak, the child fails to breastfeed, it is really not good. But there are many men who still do not understand this importance when it comes to the health of the mother. He just wants to get his children, simply because he married this woman and brought her to his home.
>
> (Vihiga District male participants in middle age group with incomplete family size from Tiriki, Luanda and Vihiga divisions)

Although the above quotations reveal that the notion of enhancing the health of a mother and her children is related to motivation for child spacing through contraception, this apparent relationship is not as simple as it may seem. While the justification of family planning for health reasons seems to have a good following in this community's approval for family planning, further examination of individuals' perception of modern contraceptive methods reveal health concerns such as secondary infertility, unplanned conception while on a method such as the coil, negative side effects such as continued fatigue or weakness of the body for women on certain methods and perceptions of loss of manhood for men who have undergone vasectomy. These are health-related factors that husbands and wives are faced with both as individuals, and even as couples in considering modern contraceptive method use.

The motivation for health reasons, just like that of economic reasons such as children's education examined above, reveals a varied situation leaving wide room for multiple results with regards to contraceptive use decision making by individuals and couples as shall be seen below.

Some husbands did seek to discuss contraceptive use with their wives after experience made it clear that frequent births were having an effect on her health as well as that of the children being born. Yet while spacing is understood to be beneficial to the health of the mother and baby, the use of modern contraceptives to achieve this does not seem to be a clear conclusion as a result of side effects, rumours, and misconceptions. Although both genders express hesitation regarding contraceptive use due to health related effects, female participants reveal a higher potential for intending to use the contraceptives despite difficulties—mainly as a result of information gathered from the social networks mentioned earlier.

Female Sexual Control and Family Planning Involvement

Husbands who participated in the FGDs also revealed widely held perceptions regarding female sexual control and modern contraceptive use. Contraceptive use was blamed by some male participants to maintain a woman's attractiveness and enhance their sexuality—providing opportunities for women to engage in extra-marital affairs;

> In family planning, the first most important thing is to
> make the women understand she has to be faithful to the husband.
> Because there has come this disease, AIDS, so that is the first
> most important thing.
>
> I agree with him very much. You know we are not refusing, family

planning is good, it means that at least one can be able to say, okay these children are enough for me I have to stop now and work hard with the ones I have. But you find that as they were saying sometimes the wife wants to do family planning and you have only two children! Now tell me how can that be. How do I stop having children and I have only just started? And you start wondering also why is this woman so keen on this family planning? Why does she want to remain a young girl?

Some women they have their own reasons. You see after someone starts taking those pills, they know they are free. They can do their things out there and you the husband cannot know. They are not afraid because now they cannot get pregnant. So this family planning, we also have to be careful about it.

That is true.
That is true.

I also agree, even if today family planning is being supported, we need to also make sure that the women are not using it for other reasons. As the man, when your wife is young you also have to be careful because other people that is what they do, they don't care, especially if you are working somewhere else, you do not know what is happening back there.

If I went and did that, (vasectomy) it will be very difficult for my wife to

remain faithful to me.

(Vihiga District male participants in younger and middle age groups from Tiriki, Luanda and Vihiga divisions)

For me my problem is that my husband is always against family planning, he says that it is for spoilt women, women who do not respect their husbands. He does not like talking about it.

You know some men say they do not mind family planning. But then they are the same ones who also say that if your wife is using family planning, it means that she wants to have affairs outside.

Yes, many men are like that. To them family planning means that the woman is free to do what she wants, so this makes it very difficult for him to accept his wife to do it.

It is hard this family planning issue. I know someone whose husband refused completely and even accused her of having affairs when he is away.

(Vihiga District female participants in younger and middle age groups from Tiriki, Luanda and Vihiga divisions)

These sentiments, held by many male participants from across the FGD divisions and confirmed by reports from the women participants, support the presence of other gender related factors that

influence men even when they generally approve of family planning and are considering involvement. The perception that fertility regulation leads to a loss of sexual control over one's wife goes a long way towards explaining the disconnect between a man's general approval, and the actual involvement of his own wife. It stands to reason that in order for the approval of family planning to translate into actual use, the processes and perceptions must be clearly understood from the community level all the way down through individual intentions and concerns and spousal level implications.

This study draws attention to the fact that notions of family planning—be they presented by husbands or wives—are more fluid in nature than commonly believed. These notions and perceptions change over time and over the life of the marriage depending on what unique combination of social, economic, and political variables each individual comes into contact with and perceived implications on the spousal relationship.

Summary

The findings provided in this section reveal varying levels of contraception knowledge and family planning approval held by FGD participants. While the KDHS data reveals both high knowledge and approval rates among the spouses in Western Province, the FGD data brings to light subtle differences in the degree of said knowledge and approval. These represent what is referred to as various levels of knowledge in the conceptual framework of this study. The levels of knowledge have implications for potential of family planning involvement at the individual

and couple levels. According to these findings, the conceptual framework seems to fall short in its ability to effectively predict how the various levels of knowledge and approval affect each other. While female participants presented higher levels of knowledge in terms of awareness, technical understanding, and self perceptions than their male counterparts, when it came to actual use, data at the couple level clearly indicated that the male's influence plays a more significant role in fertility decision-making.

High awareness of specific contraceptive methods is often coupled with limited technical knowledge about how specific methods work. Many individuals also host poor perceptions of the extent of their own knowledge, particularly men in younger and middle-aged groups whose wives are not using contraceptives.

While the high rates of family planning approval presented in the KDHS data is confirmed by a large number of the FGD participants, this generalized approval is most applicable at the local community level—influenced by the increased perceptions of the "correctness" of family planning amid difficult socio-economic conditions such as land scarcity, unemployment, and difficulty in family provision. This provides further insights into what may be seen as discrepancies when high knowledge and approval are juxtaposed with poor contraceptive use by individuals.

At the individual level, such approval of family planning is juxtaposed with mixed attitudes (simultaneously positive and negative). These conflicting attitudes are explained by what is referred to as processes and causality in the conceptual framework. In this case these include cost

of caring for children, mistrust between spouses due to the possibility of infidelity, negative health and wellness implications, myths and rumors surrounding various methods, the perceived need to achieve a desired family size while one is still young, perceptions linking family planning to a man's inability to provide for his family, and the unique challenges of abject poverty. Processes that influence differences in husbands' and wives' knowledge and approval of family planning also include popular media messages regarding the importance of family planning and these are more common in the district centers of Vihiga and Luanda, where spouses interact with local leaders, service providers, and social networks which all serve to support fertility regulation involvement.

CHAPTER SEVEN

Examining Family Planning Communication between Husbands and Wives

Introduction

Having examined the family planning perceptions held by spouses in the previous chapter, this chapter explores the reproductive health communication and resulting involvement of married couples, as well as addressing the influence of this communication on contraceptive use.

This chapter has three aims: to examine spousal family planning communication including the nature, timing, and results of said processes; to provide insights into the relationship between communication and contraceptive use between spouses; and to use these insights to provide explanations for the discrepancies observed in the quantitative data regarding spousal approval, preferences, and intentions for contraceptive use.

An analysis of the DHS quantitative data from Western Province is first provided. The quantitative data analysis provides cross-tabulations depicting husbands' and wives' reports on their family planning communication, their spouses' family planning approval, and husbands' fertility preferences in relation to their reported family planning communication with their spouses. This section raises questions regarding discrepancies between family planning communication as reported by husbands and their wives, and outlines the need for further examination and understanding of couple communication in order to understand contraceptive use implications better. The study uses qualitative data to provide further insights into husbands'

and wives' family planning communication and relates these to the various questions raised in previous quantitative studies.

In examining husbands' and wives' family planning communication using qualitative data, this study expands the notion of communication to include what is not otherwise examined in the quantitative studies, such as the KDHS. Couple family planning communication in this study encompasses a wide range of communication processes, including verbal communication and non-verbal and indirect communication processes between husbands and wives that underlie their interactions about family planning and contraceptive use and are either directly or indirectly linked to their family planning negotiations. An examination of a broader definition of communication provides a better opportunity for linking communication processes to a wider context of the couple, including other socio-cultural and political-economic processes that provide the contextual environment and ingredients for the couples' family planning communication and negotiation processes. Couple family planning communication is therefore understood not in isolation, but as informed by and in turn informing various aspects of the spousal relationship. That it need not be directly about contraceptive use, yet affect perceptions and decisions on contraceptive use or that it need not be verbally or specifically addressed is thus underlined.

An important qualifying factor when examining non-verbal communication is the fact that both genders are able to identify non-verbal forms of communication as well as allude to conscious and subconscious employment of non-verbal strategies leading to both expected and unexpected results in terms of family planning or contraceptive use.

Other studies' that present the significance of non-verbal communication include Blanc (2001), and Wolff et al. (2000). According to Blanc's (2001: 194) findings, much of the communication around reproductive and sexual matters occurs indirectly or non-verbally—at least partially because of the obstacles to verbal discussion. Studies referenced in Blanc (2001: 194) include Castle et al. (1999) in Mali; Balmer et al. (1995) in Kenya; and Blanc et al. (1996) in Uganda. Wolff, et al. (2000) also defined communication broadly in an effort to encompass both direct and indirect forms ranging from verbal discussion, to non-verbal gestures. In this study, communication is divided into non verbal, indirect, and verbal communication processes that serve different purposes and have varying outcomes for married couples.

Comparing Spousal Communication Reports

Table 8 provides comparisons of spouses' reported figures for family planning communication.

Table 8

Comparing Husbands and Wives Reports on Family Planning Discussion

	HUSBANDS			
WIVES	**0**	**1 or twice**	**2 or more**	**Total**
0	11 (42.3%; 6.3%)	12 (46.2%; 6.9%)	3 (11.5%; 1.7%)	**26 (14.9%)**
1 or twice	23 (32.9%; 13.1%)	21 (30.0%; 12.0%)	26 (37.1%; 14.9%)	**70 (40.0%)**
2 or more	13 (16.5%; 7.4%)	24 (30.4%; 13.7%)	42 (53.2%; 24.0%)	**79 (45.1%)**
Total	**47 (26.9%)**	**57 (32.6%)**	**71 (40.6%)**	**175 (100%)**

In total, 72.6% of husbands reported having discussed family planning with their wives, either once, twice or more often while 85.1% of wives reported the same. Husbands appear to report lower rates of communication when compared to their wives. The information in Table 8 also suggests that more husbands (26.9%) than wives (14.9%) report never having discussed family planning with their spouses. A discrepancy is revealed between husbands and wives regarding whether or how often family planning is discussed. While this difference may not seem significant when presented with the total frequencies in Table 8, when we actually make comparisons within couples, the discrepancy is seen to be more wide-spread. Only 24% of the couples had both the husband and the wife report that they discussed family planning more often, while 12% of the couples had both the husband and wife report that they had discussed family planning once or twice. Only 6.3% agreed that they had never discussed family planning. This means that 42.3% of the spouses' reports on family planning were in agreement, while at least 57.7% of spouses provided disparate reports regarding their family planning communication.

The kappa index is also used to examine the level of agreement between spousal reports on family planning discussions. A simple kappa of 0.1075 reveals poor agreement between reports of contraceptive use discussion. The 0.1075 score is much lower that 0.70 to 1.0, which is the commonly applied criteria indicating satisfactory to perfect inter-rater reliability.

According to the kappa index analysis, the proportion of agreement between spouses after chance agreement has been eliminated is only 10.75:100. While Table 8 reveals that at least 42.3% of husbands provided similar answers regarding family planning discussion with their spouse, this figure is lowered when the chance agreement is removed in the kappa analysis.

The low kappa index underlines husbands' and wives' differing responses when speaking about their family planning communications. The poor kappa index indicates that family planning communication between husbands and wives and its reporting in survey questions is not a simple or predictable process. The results reveal that couples provide varied answers regarding whether or how often they had discussed family planning with their spouses. The varied answers provided by husbands and wives may have implications including: reports related to other partners not part of the respondents in this sample or different understandings of family planning communication, thus what a husband may be referring to as communication may not necessarily be understood or reported by the wife as such. This further calls for re-examination of the communication concept as understood and explained by both husbands and wives. This is done using the qualitative data in this study.

The study conceptual framework provides indication that spousal communication is not a simple process, but may occur in varying levels and is informed with wide range of factors that individual partners interact with both in the community and couple levels. The possibility of varying natures and results of spousal communication could inform the varying reports of spouses as indicated in the quantitative analysis here. According to this study's conceptual framework, husbands and wives do operate with individual agency for achievement of their personal family planning goals. The couple, therefore, cannot be treated as a single unit seeking cohesive family planning involvement.

These differences in reporting between partners is important to examine and understand, particularly because various studies have described communication to be a significant condition

for family planning involvement or contraceptive use by married women (Becker, 1996; Omwanda, 1996; Ezeh, 1993).

While the findings reveal discrepancies as to whether spouses have ever communicated, or whether it was once, twice or more often, the majority of both genders report that they have engaged in family planning communication with their spouse in general.

Further quantitative data reveals what has been termed as indication of lack of (or poor) communication between husbands and wives. The KDHS questioned spouses about their perceptions of their partner's family planning approval and fertility preferences. Tables 9 and 10 display agreements and disagreements between the answers provided by husbands and wives regarding their spouse's family planning approval.

Table 9

Comparing Spousal Reports on Their Partner's Family Planning Approval

	HUSBANDS REPORT ON SPOUSE			
WIVES' REPORT	**Disapproves**	**Approves**	**Don't know**	**Total**
Disapproves		32 (76.2%; 18.3%)	10 (23.8%; 5.7%)	**42 (24.0%)**
Approves	3 (2.4%; 1.7%)	93 (75.0%; 53.1%)	28 (22.6%; 16.0%)	**124 (70.9%)**
Don't know		5 (55.6%; 2.9%)	4 (44.4%; 2.3%)	**9 (5.1%)**
Total	**3 (1.7%)**	**130 (74.3%)**	**42 (24.0%)**	**175 (100%)**

Table 10

Comparing Spousal Reports of Their Own Family Planning Approval

	HUSBANDS			
WIVES	**Disapproves**	**Approves**	**Don't know**	**Total**
Disapproves		8 (88.9%; 4.5%)	1 (11.1%; 0.6%)	**9 (5.1%)**
Approves	1 (0.6%; 0.6%)	133 (81.1%; 75.6%)	30 (18.3%; 17.0%)	**164 (93.2%)**
Don't know		1 (33.3%; 0.6%)	2 (66.7%; 1.1%)	**3 (1.7%)**
Total	**1 (0.6%)**	**142 (80.7%)**	**33 (18.8%)**	**176 (100%)**

Comparing totals in both tables, the number of husbands who disapproved of family planning rose considerably when the partner was doing the reporting in Table 9, compared to when individuals reported their own attitudes in Table 10. Table 9 reveals a total of 42 women (24%) who reported their husbands as disapproving of family planning, while only 1 man (0.6%) reported himself as having a negative attitude towards family planning in Table 10.

In Table 9, 70.9% of wives reported their husband's approval and 74.3% of husbands report their wives' approval—making it 53.1% of the couples agreeing on their partner's approval. Table 10, however, shows 75.6% of partners individually reporting approval. Approximately 20% of couples in which both spouses approve of family planning either do not know it, or think that their partner disapproves.

Becker's (1996:295) study in Kenya produced similar findings. At least 34% of wives of husbands who approved of family planning either did not know that their partners approved, or thought that they disapproved despite the fact that 85% of one or both members of these couples reported discussing family planning with their spouses in the previous year. In an attempt to explain this situation, Becker (1996) pointed to the imprecise nature of the attitude question in the DHS: "For example, the husband may disapprove of a specific method but approve in general of family planning, and the wife is sensitive to and responds to the former attitude while he reports the latter" (1996:295). This study uses its qualitative findings to better understand these communication discrepancies found in the quantitative data.

Fertility preference data from Western Province also reveals that communication between couples as reported by husbands does not significantly improve or reduce indecision regarding fertility preferences. As Table 11 shows, the 94 husbands who reported indecision regarding fertility preferences were almost evenly distributed across groups who had never discussed family planning, who had discussed it once or twice, and those who had discussed it more often with their wives.

While previous writers (see Ngom, 1997; Becker, 1996) have suggested that partners' failure to communicate may be the reason for non-use of contraceptives, these findings reveal confusion regarding fertility preferences even among husbands who have been communicating with their wives. A more in-depth examination of the content of communication between husbands and wives is thus undertaken in the qualitative data.

Table 11

Husbands' Reports of Family Planning Discussions and Personal Fertility Preferences

	FERTILITY PREFERENCES				
DISCUSSION	**Have another**	**Undecided**	**No**	**Sterilized**	**Total**
Never	10 (21.3%; 23.3%)	31 (66.0%; 33.0%)	6 (12.8%; 18.2%)		**47 (26.9%)**
Once or twice	18 (31.6%; 41.9%)	33 (57.9%; 35.1%)	6 (10.5%; 18.2%)		**57 (32.6%)**
More often	15 (21.1%; 34.9%)	30 (42.3%; 31.9%)	21 (29.6%; 63.6%)	5 (7.0%; 100%)	**71 (40.6%)**
Total	**43 (24.6%)**	**94 (53.7%)**	**33 (18.9%)**	**5 (2.9%)**	**175 (100%)**

Before we examine the qualitative findings on spousal family planning communication, there is a brief exploration of the association between individual reports and some background characteristics including age, education level, number of unions, and marital duration. These variables are selected because they provide us with a picture of how individual reports of family planning discussion can be understood in relation to various characteristics of the respondents. While it would have been interesting to include other variables in this analysis, the nature of the data collected and the limited study sample eliminated the use of variables that presented a very high incidence of empty cells in the chi square analysis. Table 12 presents the findings of the chi square and correlation analysis of the relationships between individual reports and the selected background variables.

Table 12

Relationships between Spousal Reports on Family Planning Discussions and Selected Background Variables

	VARIABLE	CHI Sq	TABLE VALUE	DF*	SIG LEVEL	LEVEL OF CONFID	PEARSON'S R
HUSBANDS	Age	10.1420	21.02607	12	0.05	95%	0.0370
WIVES	Age	19.6711	21.02607	12	0.05	95%	-0.0576
HUSBANDS	Educn level	27.2359	12.59159	6	0.05	95%	0.3755
WIVES	Educn level	8.7698	12.59159	6	0.05	95%	0.1956
HUSBANDS	Unions	4.7171	5.99146	2	0.05	95%	-0.1635
WIVES	Unions	3.4391	5.99146	2	0.05	95%	-0.1027
HUSBANDS	Marital duration	14.7487	21.02607	12	0.05	95%	0.0299
WIVES	Marital duration	28.9649	21.02607	12	0.05	95%	-0.2149

(DF* = degrees of freedom.)

Table 12 presents a statistically insignificant relationship between individual spousal reports and most of the background variables. The study does note, however, that the low statistical association between the communication variable and the background factors can be attributed to the fact that there was limited variation within the communication variable—further complicated by limited variation in some of the background variables, such as women's education and number of unions.

The Chi square analysis reveals either gender's age to be statistically insignificant in relation to their reports on family planning discussion. A Chi square of 10.142 and 19.6711 are both lower than the table value of 21.02607 at 12 degrees of freedom, and 0.05 significance level or 95%

level of confidence. The Pearson's correlation, however, reveals that while a husband's age can be positively related, a women's age tends to be negatively related to the nature of their reports. As a woman's age increases, they are less likely to report discussions while the opposite appears to be true for men. This may indicate that husbands seek to discuss family planning much later in life than their wives. While the measures of association allow us to partly understand the relationship between age and reports on family planning discussion, they are not sufficient in explaining other variables that may be influencing the association between the two variables.

The Chi square analysis reveals that the husband's education is significantly related to their reports on family planning communication. The Chi square of 27.2359 is higher than the table value of 12.59159 at 5 degrees of freedom, 0.05 level of significance and 95% confidence level. The Pearson's correlation reveals a positive relationship between these two variables, where the more educated the husband was, the more likely he was to report that he had had family planning discussions with his wife. While this is expected for both husbands and wives, the findings show the wife's education to be statistically insignificant in relation to their reports. As noted earlier, the fact that there was less variation among female education, with 55.7% reporting a primary education level (see Table 1 in Chapter 5) could have some effect on reducing said significance.

The analyses reveal a weak and negative relationship between an individual's number of unions and their reports. It is less likely for individuals in more than one marriage to report engaging in family planning discussions with their spouses.

Findings show that marital duration is both significantly and positively related to family planning discussion in the case of wives, while the same relationship is insignificant but positive in the case of husbands. Husbands who have been married longer are more likely to report having family planning discussions with their wives, while wives who have been married for a shorter time are more likely to report such discussions. While caution must to be taken when interpreting these findings, given the limited variations of the variables, a degree of consistency is revealed in the findings on how marital duration and age both relate negatively to reports on family planning discussion. The older a wife is and the longer they have stayed in a marriage, the less likely they are to report family planning discussions—according to this analysis. Factors that could explain this scenario include increased secret use as wives become older, and the elevated significance of seeking the husband's approval for younger, newly-married wives. This study appreciates that a bivariate association, as examined here, could in actual sense be effected by several unexamined factors. The qualitative data below further examines the communication variable, revealing insights about timing, nature, and content of communication processes among participants of different age groups.

Spousal Family Planning Communication Process

FGD data reveals a wide range of family planning communication strategies employed by both husbands, and wives. Communication as presented by the focus group participants included broader, more complex processes than were provided for in the quantitative surveys, which are limited to examining verbal communications. Differences observed in survey respondents'

reports on spousal family planning approval, preferences, and intentions—factors that have prompted some of the previous surveys to make conclusions that there is a lack of communication—are better understood within this broader context.

It is important to note that these family planning negotiation processes do not necessarily follow the stages presented in this chapter, nor do they proceed in the uni-linear format used here. In reality, spousal family planning communications may involve some or all of the various processes presented, and may occur simultaneously.

Non Verbal and Indirect Family Planning Communication

While verbal communication was considered significant by most participants, the notion of non-verbal or indirect communication was consistently referred to by both genders throughout the discussion groups. For the most part in both the male and female focus group discussions, family planning communication was expressed as incorporating a variety of means by which a husband or wife seek one another's attitudes regarding contraceptive use, and seek permission to use contraceptives or relay individual perceptions to their spouse.

Non-verbal and indirect verbal communication was mainly identified in what this study has termed the "Pre -tabling Stage"—when the husband and wife have not yet directly sought to discuss their contraceptive intentions with one another. The negotiation process had, however, already begun utilizing non-verbal or indirect means.

The non-verbal or indirect communication was identified in all groups across the different age groups and residence sub-areas, with a couple of exceptions by participants and spouses who both had achieved a relatively higher secondary education. A majority of these men explained that they had frequently communicated their personal attitudes regarding contraceptive use to their wives, without having actually talked about it;

> As the husband, your wife knows where you stand with family planning sometimes you do not have to talk to her about it. For me, I am sure she knew this is somebody you are living with, she has heard you talk about these things even if it is not directly about you.
>
> That is true, because for me she also knows that I do not want her to go for family planning, she has seen how I react when sometimes it is on radio, or I can just talk about it generally.
>
> My wife knows that I am not ready for her to use contraceptives. She has heard me talk about it, for example there is this man who is old, but you see very young children running around in his compound. You see I would not like that and she knows because she has heard me talk about that.

(Vihiga District male participants in middle age with young, incomplete family size from Tiriki, Luanda and Vihiga divisions).

These male participants were in the middle-aged groups and had what they perceived as incomplete family size and had never discussed their own family planning with their wives. However they explained that their wives already knew about their perceptions related to not approving contraceptive use because they had expressed their attitudes in reference to various other contexts other than specific communication with their wives regarding their contraceptive use.

According to wives who expressed their husbands' lack of verbal communication in this study, they reported that their husbands' opinions were known to them long before the first incidence of direct discussion. The wives further confirm the prevailing negativity in terms of contraceptive use intentions within the environment of indirect communication. Thus, besides the fact that the husbands were not directly discussing contraceptive use with them, they made their disapproval known using indirect means.

> You know, the wife gets to know from the way the man behaves when contraceptive use is mentioned anywhere, if she is there, she will observe the husband, and she will know, this one, if I tell him about contraceptive use, it will be trouble.

> The way he talks about the issue when it comes up, sometimes he may just make comments that will let you know that this man I cannot ask him about family planning.

> You may find that he talks very negatively about family planning. Maybe he is referring to the family planning mamas (CBOs) or sometimes it is just on the radio, he will switch off or turn the station. He can just say negative remarks.
>
> (Vihiga District female participants, middle age, in mid marriage, with incomplete family size from Tiriki, Luanda and Vihiga divisions).

As seen in the various quotes above, non-verbal and verbal indirect communication was largely negative in nature especially when coming from the husband to the wife. Instead of avoiding the subject of family planning, these husbands explained how they made their negative attitudes known to their wives using indirect conversation at spontaneous opportunities. This communication of negative attitudes makes it even more difficult for wives to bring up verbal discussion, especially when they hold differing views. Details of implications of verbal communication when spouses have differing views are further examined later.

Non-verbal and indirect communication thus serves to keep the actual verbal direct communication at bay. The negative messages that are normally portrayed by the non-verbal and indirect communications from the husband to the wife mainly serve to further delay verbal communication on the part of the wife. Incidences of non-verbal or verbal indirect negotiation include a husband communicating negative perceptions of family planning to the wife as presented in various female and male discussion groups whereby the couple does not talk about family planning yet the wife reveals being aware of the husband's perceptions regarding contraceptive use. According to various women therefore, the following quotes were applicable.

> You can know what your husband is thinking. This is someone you live with, you know what he is thinking, you do not have to ask, you can see from the way he behaves.
>
> I have never talked to my husband about family planning. I know he does not expect me to bring it up, he has made that clear.
>
> For me, I did not talk to him about family planning. I already knew that he could not agree, it was clear in many ways, like how he reacted when it came up with other people.

(Vihiga District female participants, younger and middle age group, with initial family size from Tiriki, Luanda and Vihiga divisions).

The above quotes from female participants while most common among younger participants, were also acknowledged and explained by older male and female participants. The notion of non-verbal negotiation was generally identified with couples who are still 'new' in marriage and often the husband or even the wife is still looking forward to having more children besides the initial ones before considering to actually discuss their use of contraceptives for family planning with the spouse.

> I took a long time before I spoke to my husband about family planning.
> We actually had four children, then I realized I was pregnant, that is when I decided, no I am going to talk to him.

> When you still have one or two children it is difficult, the man is very negative about family planning. Later on, his attitude changes, and you can see that he has changed and would listen if you brought it up.
>
> I always knew, (that he was against her use of contraceptives). He would always react negatively, for example if the topic comes up on radio, he would switch it off, and that is when we were just married.
>
> (Vihiga District female participants, older age group, with near complete family size from Tiriki, Luanda and Vihiga divisions)

In the quotes above, female participants in the older age group with almost complete or complete family size who were using contraceptives reflect about periods in their reproductive history when it was difficult to bring up verbal family planning communication with their husbands.

In the various groups, both male and female participants provided what seems like vague explanations of how they or their spouses get to understand their partner's perceptions without any verbal communication whatsoever. Yet for the majority of participants, the non-verbal communication is often an expression of negative attitudes regarding family planning or contraceptive use from husband to wife. As seen in the above quotes this was most common especially among younger or middle age groups, with initial or incomplete family size. Thus in these cases husbands explain that they expect that their wives are indeed aware that they are not in favor of contraceptive use (at least at that time) while as is seen in the quotes above, the wives confirm this.

Further probing reveals that part of this negative non-verbal family planning communication and negotiation from husband to wife is often understood within the context of what is perceived to be culturally acceptable or expected. Specifically for younger couples, there is generally very little or no expectation that they would be discussing family planning, as they are at the point in their marriage whereby child bearing is expected to peak for fulfilment of that marriage and also for assertions of fertility by both the husband and wife. In general, therefore, younger couples with initial family size are more engaged in non-verbal negotiation and at this point it is mainly about one spouse upholding the prevailing reproductive values within the marriage. There is more pressure for childbearing couples early in marriage and with only initial family size. The quotes below from males in younger age groups with initial family size help to illustrate their explanation of withholding family planning communication in the initial stages of marriage.

> You see, I have never talked to her about it because I married her so that I could get children with her, so how then do I start telling her about family planning? I do not want to hear about that!

> My wife and I have never talked about family planning. You see we only have two children, in fact I only have one with her, the other one was there previously from another woman. Given that we have just gotten married, we cannot start talking family planning.

> Family planning for me is not applicable to newly wedded couples. When a man marries a woman and he immediately starts talking about family

planning, she will wonder as well, this man, why did he marry me in the first place?

When a couple gets married, it is expected that they are going to have children, if they take too long, still wanting to apply family planning, people will even start asking. Your mother herself will tell you, what is happening, I want to see my grandchildren before I die.

(Vihiga District male participants, younger age group, with initial family size from Tiriki, Luanda and Vihiga divisions)

In the first few years of marriage as a woman you also do not want to bring up the topic of family planning too soon. The man can also wonder at your intentions.

When a couple is young, the woman just like the man also wants to have children, because she is now a married woman, so you have your first child, maybe the second one, then depending on your spouses, you may start thinking family planning. But for many women, it is more children first.

If you bring up family planning too soon, the man starts thinking you have other motives. He will say, 'Did I marry you to come and tell me about family planning? I married you so we can have children together'. The man starts to think that maybe you want to continue living like a single woman.

(Vihiga District female participants in younger, middle age and older groups with incomplete and complete family size from Tiriki, Luanda and Vihiga divisions)

The quotes above from males and females in varied age groups underline the perception of marriage for reproduction that is so strongly held within the local community. Both husbands and wives regard the expectation of children to follow relatively soon after marriage as important. The understanding that a couple ought to have some children before either of them can bring up the topic of family planning is thus supported by both husbands and wives and further expected within the community. For a new couple, getting their initial family size usually with mixed sex preferences is considered as the fulfillment of that marriage, while providing further social status to both the husband and the wife. A delay in getting the first children invites persistent questions from the extended family and neighbors. The study participants therefore readily agree that children are important to both husband and wife before onset of contraceptive use.

While the significance of having at least some children was widely agreed upon by participants from the various FGDs, variations still existed within this notion. For younger female participants, getting at least one child before embarking on family planning was seen as desirable, yet the same could not be said of the middle-aged and older male FGD participants. For this group, family planning was something to consider in the future, delaying contraceptive discussions for as long as the individual still wanted to get children. They provided less specific answers regarding appropriate times for contraceptive use within marriage.

Husbands could rarely agree or express when it might be appropriate to discuss or start contraceptive use, and the non-verbal communication was considered to be necessitated by what husbands perceived as the need to delay formal, verbal family planning communication. Thus the concept of non-verbal communication can also be understood as both partners coming to terms with varied perceptions regarding the prevailing values of children and marriage fulfillment within the context of social and cultural influences on contraceptive use expectations and experiences.

The findings presented here should also be examined in the light of what the conceptual framework refers to as various levels of society. While the local community approves of family planning, the value of children to a marriage continues to be a significant factor, especially for the young and newly-married. On the other hand, the need for contraceptive use is clearly promoted by national and local health and political administrations as well as being accepted within the local community. Despite the fact that fertility regulation is considered important, the notion of how many children is enough or when to start family planning is not addressed at either of these levels, leaving the decisions in the individuals' hands. As a result, non-verbal communication appears to inhibit verbal discussions that might lead to actual contraceptive use. Non-verbal communication further reveals spouses' different translation of the understandings or notions of family planning existing locally, with the husband opting to lean towards fulfillment of fertility preference before consideration of contraceptive use and seeing verbal communication as an invitation of the latter. The agency of the husbands in the above examples enhancing their personal fertility goals at the particular time in their reproductive history (early

or mid marital stage with initial family size), by delaying contraceptive use is underlined in the current study.

Factors Surrounding Delayed Initial Verbal Family Planning Communication

Various male participants underlined how they perceived family planning communication in relation to one's readiness or contemplation to engage in or encourage the wife to use contraceptives. For these men, the subject is preferably kept at bay until they perceive themselves as being ready for fertility regulation as the quotes below indicate.

> I have never talked to my wife about family planning. No I have not because I do not want her to use family planning, I still want children, so how do I start to talk about family planning?

> As a man, you have to know how to control these things, you bring up that topic, obviously you will end up in some misunderstanding. Unless I want her to use it then, I will bring it up.

> If you know you are not ready for her to use contraceptives, there is no need to encourage her to talk about it. What will happen is that you will end up fighting, because she may not understand that you are not ready!

Yes sometimes it is better that way you only talk about it when you think you are ready, otherwise what is the point?

(Vihiga District male participants in middle age group with incomplete family size from Tiriki, Luanda and Vihiga sub areas)

As seen earlier, both husbands and wives—especially in the younger age group with initial family size—explain that delaying family planning communication is mutually expected, as both partners endeavour to get their first few children. The quotes above provide a somewhat different scenario. These are husbands are in their middle age with what they perceive to be incomplete family size. In the above examples they had between four and six children, yet the idea of not discussing family planning with the wife persists in these cases not because of the desire to establish initial family size and allude to marriage fulfilment, but because these husbands do not have intentions for contraceptive use for themselves or their wives at that point in time in their reproductive history.

It is interesting to note that, refusal to discuss family planning even after they had achieved initial and incomplete family size was spread out among various men in their middle age with incomplete family size from all the FGD sub areas. Thus while the Tiriki sub area was reported especially by female study participants from the area as having men who are more traditional, when it comes to delaying of discussion of family planning, this is actually widespread across the sub areas.

There thus exists a tendency especially in the more affluent sub areas where various male participants usually without complete secondary education attest to what is seen as more modern way of thinking in supporting family planning and wives' role in family provision as seen in the previous chapter, however when couple family planning communication data is examined, differences between the participants from the more "affluent" areas of Vihiga and Luanda and those from Tiriki are more limited with the exception of the male participants with complete secondary education.

The increased popularity of more "politically correct" notions of gender within the family, through various networks including IEC exposure and social communication, seem to play a role. However, translation of this information into actual action seems to lag behind, even for participants residing in these areas.

The FGD findings here provide further insights into the quantitative findings between the association of husbands and wives age and marital duration with family planning discussion. The inverse relationship revealed for the wives can be related to wives' attempts at contraceptive use communication with their husbands after achieving initial family size. On the other hand, husbands delay contraceptive use communication to much later after achieving family size desires. These factors are further examined in the other communication processes presented here.

Below, an older male participant explains how negative, non-verbal communication preceded his verbal family planning discussions with his wife;

> With me I never used to talk about family planning. In fact she knew never to bring it up then, because I was very negative about it. But now it is not a problem, we have already discussed family planning and we can talk about it, it is not a problem. You see now we have our children, and also we need to be able to care for them properly.

(Vihiga male participant in older age group from Vihiga division)

While spacing may make sense to both husbands and wives given the positive health implications as reviewed in the previous chapter, other factors such as fertility and sex preferences—some of which are unique to the younger age group—make family planning for spacing not necessarily a given, even though it is basically understood by both husbands and wives;

> If I still do not have children, enough children, then why am I doing family planning?

> It is important to have your children when you are younger, that way you can be able to work and care for them, otherwise your family can be really doomed!

> Getting children when you are younger is important especially for the man as the head of house. You do not want to grow old when your first children

are still young, who will take care of them for you when you [sic]?

Let's say that I do family planning now, my friend here continues to have children, you see when I am getting maybe my third infant child, his will be half way through secondary school, of course he will be better off than I!

(Vihiga District male participants in varied age groups from Tiriki, Luanda and Vihiga divisions explain the significance of having desired family size before contraceptive use)

Further reflection reveals that getting the first few children when a man is old (defined by participants as having children long after his age mates) can also be a sign of an irresponsible man, especially if he is not wealthy. It would mean that he would not have much to leave for his children when he died or was too weak to work for their upkeep. Yet as seen in the previous chapter, such understanding can also be informed by factors negative to contraceptive use especially for younger or middle aged couples including the perceptions that contraceptive use may interfere with continued child birth. This scenario develops into conflict with regards to timing of contraceptive use between the wife and husband when the wife holds differing understandings of family planning and varying contraceptive use intentions.

The scenario regarding non-verbal communication seemed to differ slightly for older spouses with incomplete or near completed family sizes. In these cases, reports of the husband using certain strategies to ensure the wife did not get pregnant were common for both genders. Male participants described how the husband could sleep with his clothes on as a way of trying not to impregnate his wife, and to send a non-verbal message that he was in favour of delaying the next

pregnancy. Some wives, when discussing the same issue, explained how the husband could also pass on a message in the way he treats the last child;

> You can just know when he wants another child. You will see that he does not even want to have the last child near him, implying that he wants another one!
>
> With my husband, it is funny he would start noticing other women who were pregnant. So if my friend is pregnant or a neighbor for example, he would remind me that we got the previous child at around the same time, so what was happening?
>
> My husband usually would start treating the young child as if he were older. Sending him here and there, telling him he is no longer an infant, there will soon be another infant. That way I knew he was expecting another child, (expecting her to get another child or to conceive). That way it is difficult for you to go for family planning at that time as well!

(Vihiga District female participants in middle age group from Tiriki, Luanda and Vihiga divisions)

The above quotes from women across the group discussions who were in middle age with incomplete family sizes reveal non-verbal and sometimes indirect communication from the husbands seeking to get the next child. None of these wives reported using contraceptives at the

time that these communications had occurred. However, some wives like the one in the last quote explain the difficulty in seeking contraceptive use or contraceptive use discussion with the husband as what they may have considered as the right time sometimes occurs at relatively the same time as the husband's indirect communications regarding getting the next baby. In such a scenario, the wife has not made her interest in contraceptive use known while the husband has made his interest of having the next baby known, though indirectly. Yet the nature of this communication as depicted in the quotes above is such that it becomes part of their general communication, and becomes somewhat persistent and difficult to ignore.

One question to ask is why these wives did not, at this point, make their own intentions for contraceptive use known to the husband. The appreciation of male dominance is culturally deep-rooted, and wives fear the possible negative effects of countering the authority of their husbands, including threats of violence, marrying a second wife to get more children, and false accusations of infidelity. Yet secret use of contraceptives is one option for women in this situation, and is often accompanied by support from other female relatives, CBDs, and the husband's absence for periods of time.

With regards to averting a pregnancy, some wives explained that a woman could feign illness when she thinks she is ovulating, while others reported having gone to great lengths to travel—usually to their parents' home—in order to keep from having sex with their husband when they were ovulating. While this has been understood as an example of contraception strategy, wives agree that over time the husband begins to understand that the wife is trying to delay pregnancy;

> For me, I had my first child, a girl, and then soon after I followed with a boy. Their births were too close together. The nurse at the clinic also told me I should do family planning. But at that time I knew my husband would not hear about it. So I started to follow this one they call safe days. It is something I knew before, but when you are married, it is difficult it may work for young unmarried girls. Anyway, when I knew I was going to be unsafe, I would plan to travel, I just go to my parents place for a few days, I can even cheat that they were calling me for a specific reason, something like that. Then when I come back after two days maybe, I know I am safe. It worked for sometime.
>
> (Vihiga District female participant in middle age group, with four children, recalling her initial attempts at family planning before ever having discussed it with the husband)

In the quote above, a middle-aged mother of four recounts her attempts at family planning without actually discussing with the husband. She is aware of her husband's negative perceptions regarding her use of contraceptives and thus used other means including secret use of safe days by absenting herself when she was unsafe. For this woman, while she felt the need for contraceptive use after the first two children, discussion with her husband on the issue was not viewed as an option. As was the case for the example above, for most women found that non-verbal negotiation strategies worked for a while, but proved less sustainable in the long run when they either employed verbal communication, or conceived despite their felt need for contraceptive use.

The findings reveal that non-verbal communication tends to be negative in nature between younger and middle-aged couples in the early stages of marriage with initial family sizes, but has also been utilized by older spouses in positive terms as either partner seeks to avert another pregnancy.

Implications of Non-Verbal and Indirect Communications

The results of both non-verbal and indirect communication—particularly when it was negative in nature—were delays in direct and verbal family planning discussions. For some of these women, fertility regulation communication and eventual contraceptive use occurred much later, after multiple children had been born (as reported by older women with near completed family sizes). Others had not ever used contraceptives at the time of the study, and some (a few women in middle age) were trying to use contraceptives secretly, with varying rates of success. This scenario seems to support quantitative studies that relate reduced chances for contraceptive use to a lack of verbal communication. While the complexities of this relationship are examined in more detail later in the study, the influence of the nature of communication regarding contraceptive success is noted.

Mass media communication is another level used by national and local governments to spread messages promoting the increase of contraceptive use. This study's findings on indirect communication reveal how such messages can ironically also be used to create negative family planning communication between spouses—an avenue for husbands in particular to make their

disapproval known. In line with the conceptual framework findings reveal that individuals act as agents of causality, interacting with various elements such as mass media communication, political economic implications of marital timing, and reproductive history (initial or incomplete family size) to enhance their own fertility goals.

In all the examples of indirect communication as exemplified in the quotes above, the husband expected the spouse to rightly discern or understand them. This indeed happens and many women reported knowing the husband's attitude without having had actually spoken to him directly about family planning. Women explained how a husband's nonverbal expression clearly pointed out not only his attitude about family planning, but also his disagreement about the wife using contraceptives. The fact that the man never talks about family planning or contraceptive use, or if the subject is expressed negatively in other scenarios like reactions from radio programs, or expressions of negative interpersonal communication regarding negative effects of contraceptives on other friends or neighbors were examples of indications of disagreement for contraceptive use. Furthermore most women and men participants explained that when the husband expressed negativity about the use of contraceptives, the wife was not expected to bring up the topic for discussion. An attempt to do so would often be interpreted as an attempt at undermining the husband's (non-verbally) expressed decision for the wife not to get involved in contraceptive use.

The fact that most husbands explained that their negativity regarding contraceptive use was really within the context of the fertility desires at that period of their reproductive lives, questioning this was sometimes looked at as indication of doubting the man's ability to

effectively plan and take care of his family, a role which is constantly identified with by the men in the area, despite variety in actual practice of it by way of economic provision.

In line with the traditional deference to male authority, many female participants and some men in the older age groups agreed that even when family provision was carried out by both husbands and wives seeking to earn cash via small-scale sales, tilling well-to-do people's land, and other informal sector jobs, family planning involvement was to be initiated by the man;

> When I decide that the number of children I have are enough for me, are the ones I can take care of, then I would talk to her about family planning. There, I would have thought about my financial ability, so the wife cannot force me! She cannot force me! To do family planning before that, it is not her role.
>
> *MODERATOR: What if the mother is also providing for them?*
>
> There you have asked a good question. The problem is the wife's is not bad, she is good, for caring for children she cares for them when they are young. But when they are bigger, and you have even just two boys and one girl, you look at how much you are earning, even if she is also getting some little income and you are both helping each other, you have to think about it, you think about the land that you have, you try and divide it for them and see how it shall be, and so you make that decision to tell her that these

children are enough.

> But if we say that you have to discuss, and you say this and she says that, it will end up in arguing and every time you will be in conflict. She may say, no, let me get another one, then she goes for the injection, and another time again, she says let me get another one, there may never be an end!

(Vihiga District Male participants in older and middle ages, with incomplete family size from Tiriki, Luanda and Vihiga divisions)

The scenario as examined in this study portrays how gender relations between the spouses not only determine the outcome of communication, but also how communication occurs and whether verbal communication occurs at all. Glenn's (1987) discussion of the manifestation of power process in gender-based communication points out that the underlying expectation that subordinates (women, servants, and racial minorities) must be more sensitive and responsive to the point of view of super-ordinates (men, masters, and dominant racial groups)—rather than the other way round. In this study, since fertility regulation communication is considered a power-affecting interaction between the man and his wife, the delay of verbal communication or display of negative, non-verbal communication on the part of the man reinforces the overall delay in contraceptive use;

> Talking about family planning will come later. At first it becomes very difficult, even if the wife would like to use contraceptives, she finds it very difficult to approach the husband. You know these men, he can get

very suspicious and hostile.

I know my friend who when she started bringing up the topic of family planning with her husband, he would get very upset. You see they were still young in marriage, and the man never wanted to hear about family planning. (Vihiga District female participant in young and middle age with initial and incomplete family size)

With many men when they have just married you, they are expecting you should give birth. Also if you stay too long, after one year going to two years, people start asking, “is there anything wrong?” So me I knew never to bring up that topic. But later on, things changed, even the husband changes. For me I could see that he was ready for family planning when we had our last born, who is two now. He started making comments and I knew I had to do something.

For me nowadays we have talked about family planning. But these men, you know it does not mean that he was always like that, in fact he was not for it at all, but today I think even the children are too much for him.

With me he always used to say, let us have our children first. You know I had only one son in-between two daughters, so he definitely wanted to have more sons at least.

(Vihiga District female participants in middle age and older with complete family size from Tiriki, Luanda and Vihiga divisions)

When the wife perceives negativity in the wider picture, direct communication is normally delayed or put off. The wider picture, however, is presented by the husband and the in-laws, the socio-cultural practices that either partner is seen to adhere to, the upholding of the traditional role of the man as head of the house hold, and the number and sex of the children the couple already have in relation to the husband's perceived need at that time in the marriage.

> But you see family planning is that number that you as the man feels he is able to take care of, so when you have achieved this is when you tell your wife, now go and stop, these children are enough.

> The idea of family planning today we agree with it very much. But family planning is not just about the wife using contraceptives, you have to have the children you want first. For example this one says he has only two children, surely you cannot expect him to start family planning! So he has to make sure that his wife does not get into that.

> I have not talked to my wife about family planning. We only have one child! If she brings it up I would tell her no! But she already knows that I want more children so I am sure she will not bring it up, at least not now.

(Vihiga District male participant in middle age with incomplete family size from Tiriki, Luanda and Vihiga divisions)

Timing of communication is related to perception of fertility preferences, notions of family planning held, and desired timing for contraceptive use. However, the fact that some of these men may indeed be generally opposed to family planning and use non-verbal or indirect communication not to delay but simply deny contraceptive use is also a factor to consider. Thus the notion of use of negative non-verbal negotiation or indirect communication as delaying strategies may only be what is thought of as valid explanation or justification for their actions.

However, many older female participants revealed that husbands who had shown hostility through non-verbal communication or negative indirect communication initially, later asked them to go and make use of permanent family planning methods after having had more children;

> He used to refuse me to use contraceptives. I used to try talking to him, but he would always refuse. Now I think he realized that these children may be too much for him! He is the one who came and told me, I think you should stop now, why don't you go and have them stop you from getting more children!

> My husband used to be very hostile. You know I tried using contraceptives, the pill after two children, and then he found out. He was very upset, I had to stop. Now, much later, when we got our fifth child is when he said, these

children are enough for us, you should do the operation to stop. He has forgotten it is me who wanted to do family planning in the first place! So now I am on the injection.

I cannot do that permanent method, I told him after he told me to go for it. After my fifth child, he now has seven, (two from other women) he now wants me to stop. I do not mind stopping, but I will not use the permanent method.

(Vihiga District female study participants in middle and older age groups from Tiriki, Luanda and Vihiga divisions)

The above quotes represent women in their middle age and older who explain that their husbands sought their use of contraceptives later in marriage after they had had a "complete" family size or what was termed as too many children. However, not all women in this age group reported husbands turn around and desire for contraceptive use later in marriage. Several women further underlined that they simply had never had any positive effects from attempts at family planning communication, while for others this had never developed from the non verbal or indirect communication prevalent in the early years of marriage. Instead family planning discussion was more or less shunned and the couple had proceeded to have their current family size without contraceptive use.

While the husband's agency is noted in postponing spousal family planning communication, most men did not necessarily decide that they would use contraceptives after so many children. Communication about poor timing for contraceptive use from the husband rarely indicated when

the time would be right, in terms of family size preference. Thus the findings here can also be related to what Carter in Greenghalgh (1995: 19) calls “reflexive monitoring and rationalization”, in which fertility goals are made and changed continuously according to various dynamics that may change with time in an individual’s reproductive life.

The majority of older husbands in the current study can be seen to have as part of their influence for contraceptive use later not a preconceived fixed figure of children, but interaction with their socio-economic setting at the time and further considering other factors whose potential negative impacts had greatly reduced over time. These include: side effects and potential implication on infertility; negative impact on spousal relationship due to risk of extra marital affairs given the perceived sexual freedom provided by contraceptive use; and a general increase in trust among older couples and further the initial motivating factor, having achieved desired family size even though not numerized initially. Thus the political-economic processes that are involved in the husbands’ reflexive monitoring and rationalization continue to change over time, and husbands may indeed decide to change their mind about the use of contraceptives at a later stage in the reproductive life. This exemplifies the interconnectedness of time (stages in the reproductive and marriage periods) and levels (of communication) as exemplified in the conceptual framework.

Margolis (1985) noted that the family acted as the locus of gender conflict, with the interests of individual members differing mainly due to inequalities in power and resources. According to Glenn (1987), the family is not necessarily an entity of unitary interest, and there is a real potential for conflicts between and among its members (see also Biddlecom and Fapohunda 1998).

This study does not overlook the underlying cultural factors that obscure or hinder communication, especially regarding reproductive matters. Male participants explained that the manner in which the woman communicates with the husband and her submission to the husband's preferences are regarded as an indication of respect that is expected of the wife by the husband. Many husbands regarded the constant broaching of the subject of family planning by one's wife—even when it had become 'obvious' that the man was not interested at that point in time—as a lack of respect. Worse still, a wife who tried to 'insist' on family planning after the husband had denied her was also regarded as disrespectful and lead to consequences ranging from threats and violence to separation or the husband marrying another wife. Despite the cultural norms, some women did report a certain amount of agency at this stage;

> I knew that my husband had not wanted to discuss family planning, but you see it is the woman who suffers. I saw what having children frequently was doing to me. So I had to insist again and again, I told him how the frequent births were effecting not only my body but also my small business, in the end he agreed.

> For me, I used to ask him about family planning and he would refuse. I asked him again and again, I explained that it was for my health. I even gave the example of the woman who died at child birth. So I asked him, is that what you want, for me to leave you with these children? In the end he agreed, so now I am using the injection method.

> I started using contraceptives a while back, when I had my third child.
>
> My husband did not even know, you see I knew he was against it at that time.
>
> But he changed, he is even the one who later asked me to use contraceptives,
>
> he said the children were going to be too much for him.
>
> (Vihiga District female participants in middle and older age groups from Tiriki, Luanda and Vihiga divisions)

While persistent communication worked for some (usually after getting more children than they may have wanted), for others their linking the need for contraceptive use to their health helped to positively involve the husband. Yet for others, secret use prior to the husband coming round to accept contraceptive use is what worked for them. Others not represented in the above quotes but examined earlier include wives who continued with unmet need for contraceptive use without being able to address their husband's involvement. Unfortunately, looking at the study participants does not provide us with conclusive findings about the incidences of success, delayed success, or failure of contraceptive use—particularly given the similar socio-economic status of the above women in terms of education, age, family size, and occupation. They were all in middle age, had at least four children, and were self employed mostly in farming and the selling of produce in the market.

Further probing of the above participants revealed a significant role played by their social networks in encouraging persisting communication and the feigning of urgency of contraceptive

use in relation to health or secret use. These factors further accounted for various husbands giving in to the wives contraceptive use.

It is difficult for this study to clarify the significance of a husband's negative perceptions as communicated or understood by wives, especially in cases where the wives did not pursue the matter any further. The question of whether the wife also adopted high fertility preference and low contraceptive use intentions is difficult to discern when the data is provided in retrospect. Situations where blame is commonly attributed to the husbands are important to appreciate in understanding of these findings.

Examining Link to Quantitative Findings

The focus group findings on non-verbal and indirect communication as examined above provide insight into the perceived inconsistencies in terms of low rates of contraceptive use amidst high rates of communication that are noted in the quantitative findings above and even in other previous surveys. The high communication reported in the quantitative surveys may relate to a broader definition of communication, rather than the limited definition actually used by quantitative studies. In the quantitative survey, family planning communication as presented by the research only applies to spouses verbally discussing their contraceptive use intentions. The qualitative FGDs revealed that the participants' communication consists of much more than formal, verbal discussions of contraceptive use.

This study's findings add to the KDHS quantitative findings that reveal reports of communication occurring amidst low contraceptive use. The above examples and explanations reveal family planning communication does take place without necessarily effecting contraceptive use positively. Yet it takes place in forms that differ from the direct communication forms that are under study in the surveys that conclude discrepancies given high reports of communication and low contraceptive use. The point being made here is that respondents in quantitative surveys such as the KDHS can make reference to their wider understandings of family planning communication, especially in relation to indirect communication, which is not included in the description of communication as understood in the surveys. This question is examined in relation to other forms of communication as revealed from the focus group discussion findings. However at this point this study further notes that these participants further explain (to focus group researchers) that they are not or were not necessarily opposed to family planning but, at that time were not ready to have the wife use contraceptives, and thus expressing negative non-verbal communication was a means of delaying actual verbal communication until they were more ready for their wife to use contraceptives.

The scenario presented here, whereby no actual verbal communication has occurred yet the wife knows what is and is not expected of her by the husband with regard to family planning, further provides insight into a common occurrence in quantitative study findings. In quantitative studies on family planning like the Demographic and Health Surveys, where data is collected from both the man and his wife separately, spouses present inconsistent perceptions about their partner's family planning attitudes. The wives have usually been noted to portray a negative picture of their husband's fertility regulation attitudes, while husbands tend to present more positive

attitudes. This study reveals that this kind of discrepancy can be explained by noting that the wives might be responding to a broader definition of communication that includes negative, non-verbal messages, while the husbands are referring to an overall acceptance of family planning for others, if not in their personal situations. Yet these are finer details that at this stage of negotiation may not have been presented to the wife.

The limitation of quantitative studies and the significance of qualitative methodology are thus exemplified in the investigation of couple communication process regarding fertility regulation as examined here. Questions such as 'approval for whom', as noted by Chikamata (1996), and the observed discrepancy between communication and contraceptive use as seen in the KDHS and observed by Greene and Biddlecom (1997) are addressed by the findings of this study.

Although in some circumstances, the wife is unaware of the husband's positive preferences regarding fertility regulation. Some husbands explain that the positive sentiments they hold are not necessarily applicable to themselves and their wives at the time. They also claim that they do not see the need to express positive sentiments to their partners at a time when they are not themselves ready to use contraceptives. In this sense, the wife is essentially correct about the husband being negative, yet the husband may respond to his (at the time) unsaid approval of family planning.

On the other hand, the men--when asked about their fertility regulation attitude and preferences as examined by quantitative studies such as the DHS--respond mainly based on their general understanding and long term preferences. It is these long-term preferences that would require

verbal communication that are not known to the wife. Meanwhile, ambivalence and even negative impression is portrayed to the wife who would opt for immediate family planning for spacing. It is the lack of direct and verbal communication, not communication in general, that serves to keep the husband's general positive yet long-term attitude secret from the wife. The fact that this is usually done knowingly reveals that it is sometimes a form of strategy, and encouraging open, verbal communication would not necessarily be successful, especially if the method is seen to be working by the husbands employing it.

Given that this strategy of delay of verbal communication through non-verbal and indirect communication as with the other communication strategies are linked to fertility preferences, contraceptive use perceptions and understandings of family planning, an emphasis on dealing with these factors to encourage communication that bridges these areas of understanding would provide more potential than an attempt to simply increase general spousal discussion.

The Actual, Direct, and Verbal Communication Processes

The "Pre-Tabling Stage" examined above gives way to what is termed "Tabling Stage 1" when the actual, verbal, and direct communication regarding contraceptive use begins to happen between spouses. Elements that appear to positively influence such communication includes the woman's continued reproductive health education at the clinic, the influence of a community based distributor as well as friends, neighbors, or sisters-in-law;

> We talked but he refused. He said I do not want to hear about that topic.

I don’t know why he said that. Then I came here and I told sister to help me, because I wanted family planning. She checked me and told me no my blood pressure would not allow me to use the other contraceptives except the condom. When I told my husband, again he said, I shall beat you! I tried talking to him nicely, but he refused. Another day I told him, just lies, that they (at the clinic) had told me if I got another child I would die. He said I do not want to hear those lies. But slowly, we started to use the condom, but again another day he burst it! Now that I have gotten five children, I don’t know how it shall be. I have talked to him again, but he just kept quiet.

(Vihiga district female participant from Tiriki division, middle age, with completed family size)

For me I am using the injection as I said earlier. I have four children now. I started after my last child. I told my husband about it, I told him they had told me to do the family planning at the clinic, he was hesitant at first, but he did not really refuse. So I spoke to him again, and after a while he agreed, so I went ahead and started using the injection.

(Vihiga District female participant from Luanda division, middle age, with completed family size relays how the decision for her to start using contraceptives was reached after verbal communication with her husband after their last child)

I started using the pills after my fourth child. I had actually wanted to start after the first two children, because they came quite close together. But at first

> my husband would not hear anything about contraceptives. But after the fourth child, I decided I had to get him to understand. So we talked about it, he was hesitant. The nurse at the clinic also really talked to me about family planning. In the end he agreed, so I am now using the pills. We will get other children maybe, but it was important that I rest a bit.
>
> (Vihiga District female participant in middle age group from Vihiga division)

The quotes above reveal varying processes of spousal family planning communication with different implications for the wives' contraceptive use. The first quote from a woman in Tiriki exemplifies women who reported to have continually tried to involve their husbands or seek their approval for family planning without much success. The desperation on the part of this woman and others in the FGDs is seen in the explanation provided that if she does not use contraceptives, they were not only risking her health but her life as well. This explanation was commonly presented by various participants from different group discussions with varying success, and a similar explanation was presented in the quotes on wives' agency earlier.

One thing that the above quotations illustrate is the requirement of persistent communication, usually transitioning to verbal communication, before contraceptive use can become a reality. For some, this communication was applied simultaneously with secret use, which proved successful for some, and not for others.

Another factor revealed by study participants in the above quotes is the increase in verbal communication as among older or middle aged participants, who already had at least three

children. This can be explained by the fulfillment of marriage as expected in the local community by the existing children already borne, and further the involvement of women at this stage in more substantial input into family provision despite informal employment. A general expectation of understanding between the spouses is therefore more common at a later stage in marriage than initially when couples are yet to establish any family size. The challenge in this scenario is to enhance women's empowerment through education and adequate employment, while strengthening the spousal negotiation communication that becomes important in advancing verbal family planning communication and achievement of positive results.

Verbal and direct communication was widely reported by wives of various ages to entail the wife to seek permission to use contraceptives from the husband. Many participants, both male and female, explained that the community perceived such permission seeking as both desirable and significant for the success of family planning. This makes such communication a prerequisite for many wives who intend to use contraceptives. For most of the couples, particularly in the rural areas, the first attempt at verbal direct communication was met with opposition from the husband;

> My husband was very hostile. When I had given birth to my second child, after I finished six months I got pregnant again. So the third child came too soon. That is when I tried talking to him about family planning, but he refused, so I just left it at that. Again I got pregnant, but he still refused. He just used to tell me you give birth until the children reach the number that I want and then you shall go and have the permanent method.

(Vihiga District female participant, in middle age group with incomplete family size from Luanda division)

The above quote describes sentiments relayed by a majority of women in the various groups in relation to their first attempts at verbal spousal family planning communication. The fertility regulation intentions of the participant above were different from her husband's. She was aware of her husband's negative attitudes, yet the frequency of her births motivated her to bring up direct communication about contraceptive use with her husband that ended in his refusal and her getting pregnant again. Given that various women participants relayed similar experiences, first time direct verbal communication seems to have a higher 'failure' rate. The context of time is therefore underlined specifically in terms of couples' reproductive and marital history and these are perceived differently by husbands and wives in terms of readiness for contraceptive use.

Husbands explained that for many of them, these initial attempts at verbal communication come 'too soon'. 'Too soon' implying that they have not achieved their desired family size yet, and would prefer their wives to engage in contraceptive use only after this is attained. However, it is also important to note that this desire had in most cases not been communicated to the wife.

The current study further reveals that as with the participant quoted above and other participants with similar experiences—usually with incomplete family size and experiencing misunderstanding with the husband in relation to contraceptive use timing—the husband may often not reveal his fertility preference in relation to contraceptive use even though he underlines the need to get a complete family size before contraceptive use. Looking back at the quantitative

findings that revealed wives as not being aware of husbands' positive attitudes, the chances of providing a negative answer are high. Again the reason is not because she is unaware of her husband's otherwise positive intentions, but because the husband indeed has negative attitudes and intentions from the point of view of the wife, given his refusal for the wife to make use of contraceptives for spacing even after direct verbal communication.

Yet the husband has usually expressed negative attitudes with the understanding that he will only express positive attitudes when he is ready. Thus again, for some couples it is not the lack of communication but indeed as a result of negative communication that the wife relays her husband's attitudes and intentions as negative. This further provides explanation to quantitative findings revealing high communication rates amidst poor contraceptive use rates.

Looking at the husbands' own explanations for insisting on a delayed contraceptive use, a majority of these husbands were men in middle age with what they considered as an incomplete family size. Their intention, as explained by themselves, was that they aimed at having a complete family size before they engaged their wives in family planning communication and use. The following quotes illustrate.

> You see a couple should have at least three to four children before they can start discussing about family planning, because sometimes you may get your first two children and they are only girls and when they get married you are left alone in the home!

> Family planning is not always good. Like me I only have one child, the next one is on the way, so how do I start talking to my wife about family planning? We haven't even made our family yet, I would rather have stayed without getting married then!
>
> (Vihiga District male participants, middle age with incomplete family size and initial family size from Tiriki and Luanda divisions)

The quotes above are specifically applicable to husbands in the middle age and younger groups with initial family size. They explain their quest to delay family planning and contraceptive use communication with the wife until a later stage when they would have had a considerable family size.

It is however important to underline as already seen earlier that the delay of family planning communication was not limited to younger men with initial family size. The question of whether this explanation was provided by some men for the purpose of justifying their actions for the group discussions therefore arises. Further still, could the explanation as provided by several male participants be post rationalization?

From understandings of other views provided within the context of this study we may make various conclusions with regards to husbands who responded negatively to wives initial attempts at family planning communication.

Either they were generally negative towards family planning as their wives revealed, and only tried to explain themselves as only seeking to delay use, or they felt that it was too soon to engage in contraceptive use. Reasons for this included strong positive fertility preferences and children's value as seen in the previous chapter, and some husbands understanding of family planning in terms of limiting births after achieving the number of children that one can care for. Furthermore, related to that, the fear of side effects and implications for secondary infertility are all factors that have influence on husbands' negative responses especially to first time attempts of verbal direct communication by their wives.

Culturally, the man justifies his actions based on the fact that he chose to perceive himself as playing the role of provider to the family and as the household head, expects the wife to seek permission for contraceptive use, resulting from their gender status in the hierarchical structure. Therefore not only the occurrence or non-occurrence of communication are impacted on, but also the nature and expectations in communication. Yet the man and woman though married can be seen to be drawing from differing subjective realities. At this stage, the man who prefers to acquire his family size before contraceptive use mainly engages in the denial of permission to the wife. The woman on the other hand seeks to engage in contraceptive use for spacing.

Husbands and wives, though married, can be seen to be drawing from differing subjective realities. At this stage, the man who prefers to acquire his family size before contraceptive use engages in the denial of permission to the wife, while the woman seeks ways to engage in contraceptive use for spacing;

> I knew the number of children that I wanted to have, so I could not agree to family planning when she asked.
>
> One should give birth to at least three children before they start talking about family planning. You see how do you decide to do family planning after two children yet maybe they are only girls who later get married and you are left child less.
>
> Family planning for me means I should get the children I can care for. So I did not see the reason to talk about it before I get the children.

(Vihiga district male participants in middle age and younger age groups from Tiriki, Luanda and Vihiga divisions)

Despite the explanations provided by the husbands, another factor that led to disagreement was misconception and mistrust regarding the sexual freedom that contraceptive use was believed to give the wife;

> You see as the man, when your wife starts talking about family planning, you are thinking, now this wife of mine, what will happen when I am not around for example, you know when a woman is young, you never know, others can take your wife away.

Contraceptives they say they keep the women younger, so when she indicated she wanted to use, I could not just agree immediately. I have to first find out what her real motive is, if she just wants to be free to do whatever she wants or what. Because you see when a woman is using contraceptives, they will not think, no I will get pregnant! So they are free to do what they like, and if it is your wife then that is a problem. So I have to first see if she is just being influenced by her friends or she is serious about this family planning.

(Vihiga District male participants in middle age and younger groups from Vihiga and Tiriki divisions)

And also some men think they have now given you the freedom to go out with another man. That is what some of them think, especially for women whose husband is working outside, it is very difficult for the man to agree. You see when they are talking out there with their fellow men that is what they are telling, that if you allow your wife to do family planning and you are not even living with her you are just servicing someone else!

Is that true?

That is not true and men need to understand that.

(Vihiga District female participant in middle age group in middle age group from Vihiga division)

The above quotes from husbands and one female participant reveal what was reported by both husbands and wives in the FGDs. The notions that contraceptive use is related to infidelity among women in that it removes the risk of conception and that the methods further enhance a woman's beauty were commonly presented by male participants and female participants in explaining their husbands or other men's perceptions. These two notions point towards what the FGDs revealed as having negative contraceptive use implications specifically among younger couples and middle-aged men with younger wives. The modern contraceptive methods are thus seen by these groups of participants as having social costs in terms of ones wife having relations with other men, or one's wife identified more with single women.

While a man having a relationship with another single woman is not perceived as significantly wrong within the community, adultery by the wife is strictly forbidden and invites ridicule, separation, divorce, or the marrying of another wife. A husband whose wife is engaged in adulterous affair is also deemed to be weak and unable to effectively head his home. The linking of contraceptive methods to the wife's possible increased infidelity is specifically considered by younger and middle-aged husbands with younger wives. On the other hand, increased trust between partners and inapplicability of this notion in terms of the use of contraceptives to stay young can be said to relate more to the older couples.

It is also important to note that even in cases of husbands who had agreed and given permission for early contraceptive use, the desired spacing was not adequately attained and conflict still arose about the timing of the spacing. Even when the wife is using contraceptives, the male dominance in the relationship allows the husband to stop their wives from using the method if he

decides that the time has come to have the next child. This reveals that male involvement does not necessarily mean the wife's achievement of her family planning goals and intentions. This further highlights the need for caution in the pursuit of enhancing men's involvement in family planning and reproductive health.

Secret use of contraceptives on behalf of the wife counts as agency in the conceptual framework, alongside the success or failure of convincing their husband to allow contraception. For majority of wives in the current study, agency is seen in their persistent insistence on communication with the support of social networks and family planning service providers. Given the initial failure in achieving contraceptive use that the majority of these participants experience, this study points out the limitations related to the agency of wives here.

Another important aspect of spousal communication is the concept of continued negotiation. Participants indicated that the negotiation process may continue after the husband approves of the wife's desire to use contraceptives. In cases where the couple is still having children, the process of negotiation continues in relation to the timing of the subsequent births;

> My neighbor, they had two girls. He told his wife you go and they put for you that one for five years. But after one year, he told her you must go and tell them to remove it because I now want a child, we cannot wait for five years! He became very hostile, so she went, but they were asked to give three hundred shillings, the man refused. The woman did not have the money, so nothing was done. Now the man has married another wife, because you see

he has felt like getting a child. So these men really cannot be trusted.

"Alice" has five children. They have been using the condom as a contraceptive method but she says she conceived the last child when the husband removed the condom without telling her, because he never really liked using them but he does not want her to use other contraceptives.

Understanding each other about family planning is not something that happens in one day. The couple has to keep on talking about it until they reach an understanding.

(Vihiga District female participants in middle age and older groups from Tiriki, Luanda and Vihiga divisions)

While verbal communication for many couples may lead to eventual contraceptive use, the participants explain that the potential for subsequent discontinuation of said method or conception despite use is a reality that must be taken into account.

Previous quantitative studies have portrayed men as barriers to contraceptive use, underlining a lack of communication as a significant deterrent. This study's qualitative methods, however, show that initial acceptance and use in itself may not break up a barrier. For many couples, these barriers continue to be erected or lowered at various points in their reproductive cycle. While this explains the unmet need for spacing experienced by many women, the situation also provides

insight into the high dropout rates of contraceptive users, and inconsistent use of contraceptives as recorded by various quantitative studies (see NCPD and Macro International, 1999; 1994).

While subsequent communication is revealed as better related to contraceptive use, the current study highlights reports by both husbands and wives regarding the non-communication of fertility preferences especially common in cases where communication has failed to lead to contraceptive use. Spouses thus report having had family planning communication without having communicated their fertility preferences. Reports of "when I get the number of children that I want" were common among male study participants, while wives reported husbands not necessarily revealing what this number was. The various forms of communication discussed thus far (including non verbal, indirect, and initial verbal direct forms of communication) all have the lack of fertility preferences communication in common yet they all have higher chances of lack of contraceptive use. The lack of husbands communicating their approval of communication was discussed earlier.

The vagueness in presenting fertility preferences as is commonly seen by various participants in the current study hinders proper communication of the spouses intentions, further enhancing what are reported by surveys as discrepancies in spousal reporting. For contraceptive use, a lack of communication specific to fertility preferences further reduces chances of couple involvement in decision-making even when both partners express approval for family planning. Thus the significance of family planning communication content in enhancement of contraceptive use is underlined. Communication of contraceptive use by itself without adequate communication about fertility preferences hinder its resulting in contraceptive use.

Wife to Husband Communication

While disagreement and permission denial are common in initial negotiation attempts, this is bound to change for many couples in subsequent attempts. Such a change usually happens when the couple has achieved a considerable family size with an acceptable mix of genders among the children. According to most women, men also reach a point where the economic situation calls for their involvement as they are increasingly burdened by the economic provision of the family. Thus gender roles clearly impact on individual interests in family planning in manners that are peculiar to each spouse's reality for many couples.

A common negotiation strategy that emerges consists of the wife seeking the assistance of a third party in their efforts to influence the husband to change his attitude towards family planning. These third parties are often service providers, usually the Community Based Distributor (CBD) on behalf of the wife;

> Most women in my area, when I go and talk to them about family planning, they tell me, 'That is good, even me I want, but you come when my husband is there, because you see he will not listen to me!' When I go back, I pretend I had not spoken to her earlier, but I really focus on the man, in the end he says he shall make up his mind. Later I see the woman coming to me!
>
> (Extract from a Community Based Distributor of Contraceptives in Vihiga)

The significance of community based distributors in enhancing the women's negotiating capacity and eventual contraceptive use cannot be undermined. Some women who are engaged in small businesses or provide input for the family's upkeep also develop a bargaining position in the negotiating process;

> You see the frequent pregnancy really affects the woman's business negatively. Some women thus decide to use contraceptives secretly and after a while the husband may see the positive difference and he just accepts the family planning!

> You know for me my pregnancies have always been very difficult. When I am pregnant my business would always suffer, and after I had three children, I had to insist on family planning. He agreed, I know he also saw the things I was able to do when I was not pregnant were more, and I really was taking care of the family in many ways.

> My husband started to go to the next town to look for employment. He saw life had become difficult here. In the mean time I found that I had to do more to take care of the children. You seen when one is gone, you have to work extra hard. I dig for people, I sometimes sell at the market, and he has seen that I can provide for the children. So the other time I told him, I need to do family planning if I am to get serious with the works that I do. He agreed, it seems he has realised that I actually do a lot and this is affected.

Vihiga District female participants in middle age groups from Tiriki, Luanda and Vihiga divisions)

The above quotes represent situations whereby women use their self employment activity to engage husbands in family planning communication and bargain for contraceptive use. In the second quote, the woman explains how the ill health that came with frequent pregnancies on her part impacted negatively on her income earning activities. Thus the health of the mother as was seen in the previous chapter seems to be a factor for husbands' involvement and wives use of contraceptives. Furthermore, according to these participants, the health of the mother influences male involvement as a result of various implications on the woman's performance of her roles in the family, specifically that of income earning and provision.

The involvement of women in income generating activities has meant increased chances of family planning involvement for some. However, it is important to remember that the majority of the participants referred to their husbands' negative attitude, despite the fact that almost all participants were involved in income generating activities—including farming, selling produce, or small scale trading. Earning an income cannot be presented as a blanket factor for bringing about positive male involvement.

Husband to Wife Communication

This stage may not be a continuation of the above stages, but there were cases where the husband, after having denied the wife permission to use contraceptives consistently, asks the

wife to go for the permanent method of family planning (tubal ligation) once the desired family size had been reached or exceeded. This type of direct communication is most common among older men and was usually met with resistance from the wife—particularly when asked to submit to the permanent method of family planning.

This stage of communication provides us with a scenario of spousal agency that is unlike the previous examples. Resistance on behalf of the wife may prompt the husband seek to involve the CBD in order to persuade the wife. The husband may also resort to threats or force in trying to impose his decision. Many women did not trust their husband's intentions, citing cases of husbands who had remarried or had other children outside the marriage once they had persuaded or forced their wives to go for the permanent method;

> At first she had refused, she thought maybe I was telling her to go and do TL and then I go and marry another wife.
>
> That is the problem, many women when you tell them to go for family planning, they get suspicious, they think you want to marry another wife, or maybe you are having children outside.

(Vihiga District male participants in older and middle age with complete family size from Vihiga and Luanda divisions)

In the above cases, these men already had completed family size, and now wanted their wives to go for the permanent method. Thus at this time in their reproductive life, the man is not only for

family planning, (even though he may have expressed negative sentiments earlier when they had smaller family size) but he also wants to determine the type of contraceptive (permanent method) the wife is to use. Again this can be linked to the notion of having the children he can afford to (sometimes more) before contraceptive use.

In the Luhyia community, as discussed in the opening chapter, children belong to the father. Whether a child is born within or out of wedlock has no real implications. Children born out of wedlock are fully recognized by the father and his family, and are more often than not taken in by them. While most women and some men attributed the growing unpopularity of this practice to the hard economic conditions and the inability to provide for all the children successfully, it continues among the Luhyia people. While some men embraced the culturally accepted practice of outgrowing (getting children outside an existing marriage), the male permanent method was not suggested or discussed by either man or wife, because the rumors and stigma surrounding the method in the community were too well known by both genders.

Examples of power sharing are brought out in the Vihiga study when women assert their power by either refusing to go for the permanent method, or undertaking said method in secret. The first allows a woman to maintain the ability to bear children to guard against outgrowing and even polygamy. The second allows a woman to achieve their goal of stopping reproduction while managing through the deception to help the man refrain from adding to their family size by outgrowing at a later stage.

Unmet need for spacing is felt and endured by the wife before any verbal communication regarding family planning is undertaken. Instead of risking rebuke, threats, and accusations regarding her sexual freedom, the woman often delays fertility regulation communication for a considerable length of time before bringing it up verbally. Verbal communication for many women only comes after unmet need has already been experienced, and when it is 'a bit safer' in terms of sexual freedom by the man. This study expands the issue of unmet need, linking it to unmet need in communication where the wife desires yet may not undertake verbal communication with the husband when the wider picture presented and the husband's attitude is understood from indirect and also non-verbal communication as posing hostility.

For demographers and family planning programs, the significance of the gender power process in communication and decision-making lies in the impact this has on contraceptive use and reproductive health. Unmet need for spacing is identified in this study as highly gender-related. Margolis (1985) notes that like other power relations, gender is constantly being re-negotiated and reconstituted. In the case of the negotiation process between spouses regarding contraceptive use, the negotiation comes in the form of revisited attempts at discussion or secret use, followed eventually by communication with a swifter, more positive impact on contraceptive use at a later stage in their reproductive and marriage life.

Summary

Spousal family planning communication is significantly varied in terms of definition, type, content, timing, and implications for contraceptive use. Unlike in the KDHS quantitative survey, where spousal family planning communication was defined as spouses speaking verbally about fertility regulation, the qualitative findings reveal varied forms of family planning communication between spouses, including non-verbal and indirect communication that does not touch directly on spouse's own contraceptive use intentions; and verbal direct communication which entails actual talking about family planning or contraceptive use for the spouse's personal use.

Overall findings reveal family planning communication does not necessarily lead to contraceptive use. It is not just a lack of spousal communication, but also the content and motivation of said communication that produces the seeming discrepancies in spousal reports. Looking at the actual direct communication, the current study reveals better relations to contraceptive use compared to non-verbal and indirect communication. However, chances of success seem to relate to whether it is an initial attempt at discussion, or subsequent ones—with the latter having a higher success chance.

Couple communication regarding family planning occurs within the context of the gender power relations between the married man and his wife. This power relation has an influence on the quality of the fertility communication. The timing of the communication in the reproductive cycle of the couple, the nature of communication (verbal or non-verbal, direct or indirect), and

the completeness and success of the communication are all factors that are highly significant when considering reproductive health enhancement.

CHAPTER EIGHT

Conclusions and Recommendations

This study has examined the understanding of family planning held by husbands and wives and their communication processes. The study started with the premise that men play a critical role in the enhancement of contraceptive use and fertility regulation, that spousal family planning involvement relates to comprehension of family planning that falls beyond the typical aggregate examination of awareness and approval, and that the relationship that exists between family planning communication and contraceptive use is not simple and linear, but considerably complex—with potential for varied outcomes. This final chapter presents the major findings of the research and provides conclusions and recommendations for further research related to understandings of family planning, communication, and couple partnership.

The culture and political-economic framework of fertility, as presented by Greenhalgh (1995), provided guidance for this study. The potential multiplicity of realities between husbands and wives and their agency as they interact with contextual elements inform their individual perceptions of family planning and communication. These understandings of family planning and spousal communication processes are examined for variations in timing in terms of age, marital history, and family size; the various concepts examined for understandings of family planning include knowledge, approval, and motivations for contraceptive use.

This study used KDHS quantitative data on married couples to provide comparisons of their family planning knowledge, approval, preferences, and intentions for contraceptive use—noting

the limitations of such data when trying to explain spousal influence and involvement in family planning. The qualitative data provided by the FGDs shed light on how spouses seek to avoid or get involved in family planning given their knowledge, attitudes, preferences, socio-cultural and political-economic factors that provide motivation or present restrictions for family planning involvement. Perceptions of family planning become broader as they examine what husbands know about family planning and contraceptive methods, whether or not they approve of the use of the methods, and how they seek to apply family planning and contraception to their own personal relationships.

The findings of this study show that understandings of family planning held by husbands and wives influence their motivations for family planning involvement and the timing for use. Yet understandings of family planning incorporate various aspects, including individually held knowledge of family planning, attitudes about contraceptive use, perceptions regarding negative impact of contraceptive use, and perceptions regarding family planning involvement for the individual and or their spouse in relation to socio-cultural, political economic factors that inform motivation.

With regards to knowledge, the study reveals that family planning knowledge held by husbands and wives as provided by study focus group discussion participants' is varied from the almost unanimous picture provided by the KDHS survey. The study presents knowledge in terms of:

i). Awareness of various contraceptive methods by husbands and wives: This aspect of knowledge is high for husbands and wives in both KDHS survey and focus group discussion.

Study participants could name both male and female contraceptive methods and express awareness of their availability.

ii). The focus group discussions also revealed limited knowledge especially for many husbands and also for some wives on technical aspects of contraceptive methods and how they work. A majority of male participants do not know how most of the contraceptive methods work and are aware of or hold various myths, rumors and misinformation regarding the side effects of contraceptive methods use. The various myths, rumors and misinformation are widely known in the community and are enhanced by social networks both among men and among women.

While this negative information regarding contraceptive methods is well known, this study reveals social networks among wives to be significant in enhancing contraceptive use intentions despite negative knowledge about contraceptive methods. Social networks expose women to friends, relatives, neighbors who have successfully used various contraceptive methods and these, act as promoters for the methods against the widely held myths and rumors. This study thus underlines the significance of social networks specifically among women in enhancing contraceptive use intentions. Previous findings that have noted the significance of social networks among women in enhancing contraceptive use include Madhavan, et al., (2003); Kohler, et al (2001); and Rutenberg and Watkins, (1997).

The positive impact of social networks on enhancing contraceptive methods knowledge, countering myths and rumors, and enhancing wives' contraceptive use intentions can be related to the relatively higher rates of ever use of contraceptives. Thus with the number of individuals

having used contraceptives at any one time before having increased, women have more exposure to individual experiences and outcomes that refute especially the myths, rumors or misinformation. Insights provided by the current study reveal that the nature and implications of side effects are also better understood by previous or current users who then provide more precise or elaborate information to would be users in their or their friend's social networks.

Men on the other hand are limited in accessing such networks as contraceptive methods in use are mainly female methods and communication regarding family planning reproduction in general is more within gender boundaries thus it is hardly expected that they would receive such information from other women users who are not their own wives. Yet limited knowledge as noted here negatively impacts on the husband's initiation of spousal communication thus limiting acquisition of further knowledge from this direction. This study underlines the limited effect of mass media and family planning programs services in enhancing knowledge of family planning that actually translates to contraceptive use intentions. While both men and women are exposed to such knowledge through the mass media, women are further exposed through interpersonal communication with family planning service providers, and further-still to social networks such as friends, neighbors, sisters in law and their friends and relatives who are significant in enhancing contraceptive use intentions.

The significance of interpersonal communication and communication with other users with positive experiences is therefore underlined in the current study. However, still in this regard, the current study further reveals the role of Community Based Distributors (CBDs) in providing some interpersonal communication to husbands in the study area, upon the encouragement of

wives and in some instances this proves significant in enhancing husbands' knowledge of contraceptive methods and use intentions. Various female study participants revealed how they secretly requested the local CBD to help convince their husbands to allow them to use contraceptives. Men are thus increasingly being reached by community based distributors though accessibility of local family planning programs services by majority of husbands remains limited.

iii). Another aspect of knowledge as presented in this study is the self-perception of knowledge held regarding contraceptive methods. Majority of husbands reveal very poor perceptions of their knowledge of contraceptive methods and how they work. While this is related to the high levels of myths and rumors under this level of knowledge, the study reveals individuals own perceptions of the quality of the knowledge they hold. This is expected to have some impact on the individual's readiness for contraceptive use as it points to significance of their knowledge of contraceptive methods for their family planning involvement intentions. Perceptions of limited knowledge held by the individual man act as a hindrance to his readiness for contraceptive use for himself and or his wife for some and for others negatively influences readiness in bringing up the topic of family planning communication with their wives. Thus both husbands and wives in the study confirmed that many men withdraw from discussing topics like family planning especially if they feel inadequate in their knowledge of the contraceptive methods.

While the agency of both genders is revealed in terms of acquiring various aspects of knowledge of family planning and motivations for contraceptive use, this study's findings reveal that the significance of the dominant partner cannot be downplayed as far as actual contraceptive use is

concerned. However, the gender of the dominant partner may vary from husband to wife at different points during a couple's marital and reproductive history.

Looking at approval of family planning, the current study began on the premise that, while quantitative studies provide highly positive attitudes of family planning by husbands and wives, the link to contraceptive use and intentions is more complicated and there is a need to further examine family planning approval by husbands and wives in order to understand the linkage or lack of it to family planning involvement.

The findings in this study firstly reveal that when specific couples are examined, family planning approval agreement between husbands' and wives' reports are not unanimous as provided by studies that examine approval at the aggregate level. Thus various wives in the KDHS data had husbands who did not necessarily approve of family planning. The study reveals that while these husbands do not report disapproval, they are uncertain about their approval of contraceptive method use. While other factors too not studied in the current study relate to non-contraceptive use, the current study underlines the uncertainty by husbands that is not shared by their wives as one of the potential factors for differences in contraceptive use intentions.

The findings here address the questions of "approval for whom" raised by previous studies and considered to be significant in understanding the gap between approval and contraceptive use. The qualitative findings reveal various aspects of family planning approval.

i). The general approval of family planning is revealed in both KDHS and FGD findings. The qualitative findings further suggest that there has been a social shift from widely-held, negative perceptions of family planning to the present recognition of its role in addressing the changing socio-economic conditions at both the community and family levels. This is further related to family planning media messages and increasingly popular idea that family planning is today important as a strategy for the difficult socio-economic conditions prevailing. This nature of family planning approval is however more at a general level and not necessarily linked to specific individual context. This study notes that this general level of approval is responsible for the high approval figures recorded in previous quantitative studies.

ii). The approval findings also revealed participants who, while aware of and even reporting approval of family planning at a general level—do not individually relate to the need for family planning for socio economic reasons due to abject poverty and thus the perceptions of the insignificance of family planning for purposes of family provision. These husbands are thus unlikely to engage in or encourage wives involvement in contraceptive use.

iii). Another aspect of family planning attitudes revealed by this study is the holding of twin perceptions of approval and disapproval (often by men). Positive attitudes were justified by socio-economic factors, while negative ones were attributed to fears regarding contraception's effects on the health and fertility of the user (perceived and real side effects) and perceived negative effects on the couple relationship. The latter is related to factors such as fears of potential infidelity due to sexual freedom that contraceptive use provides women, and potential conflicts related to fertility preferences, timing of contraceptive use and methods for use.

Strategies for family planning involvement for these participants include delay in contraceptive use, denying contraceptive use to especially young wives, and further emphasis on family size and sex preference achievement.

According to this study, family planning approval varies in nature, and the nature of the approval is better linked to family planning involvement than assuming a simple connection between approval and expected use. This study sheds light on previous study findings that revealed high approval rates amidst low contraceptive use.

The motivating factors for family planning involvement show that spouses are influenced by a wide range of socio-cultural and political-economic factors including land scarcity, and aspiration for children's education. While these have a positive influence, other factors support negative perceptions including concerns about the health of mother and child, misinformation regarding side effects, and issues of sexual freedom. The relative influence of each of these factors is noted to vary between spouses, yet is dynamic, changing over the course of a couple's reproductive history. This provides the potential for conflict and contraceptive use negotiation.

Thus husbands and wives motivations for family planning involve dialectical relation between them as individuals and as spouses with the socio-economic and cultural motivating factors named, their levels of knowledge, approval, fertility preferences that also keep changing or developing for many and the husband or wife acting as the human agent respond differently at varying stage. For the wives in this study for example the late marriage stage provides a situation where they reject permanent contraceptive method use largely relating this to socio-cultural and

political-economic setting prevailing at that time. Thus refusal to do tubal ligation is to exert some power over the risk of the husband *outgrowing*, or seeking to make another family, factors that impact on the wife both emotionally and economically as well, having already made significant contributions to the available family wealth that would be earmarked for redistribution if outgrowing or polygamy occurred at that stage.

Women's refusal to use the permanent contraceptive method as revealed in the current study further adds insight into the otherwise limited knowledge regarding the role of women in acting as barriers in contraceptive use (see Greene and Biddlecom, 1997). The reversal of gender power in influencing contraceptive use or non use in favor of wives in the later stages of marriage provides further insight into what Ngom (1997) referred to as unmet need for limiting for men. According to this study, some of the women who refused to undergo Tubal Ligation had previously wanted to use contraceptives but been denied by their husbands and had thus experienced unmet need for spacing during the better part of their reproductive history. The refusal for using the permanent method however applies even for women who may share similar preferences and intentions, that is, already perceive themselves as having a completed family size, or one that surpassed desired family size. Thus refusal to use TL can be regarded as impacting on unmet need for these women just as much as for their husbands, as they chose to go against what they themselves realize as their fertility goals for the sake of highly placed social stakes as explained above.

Given that some of these women however go ahead to ether use the permanent method in secret, or take on other contraceptive methods serves to reduce the actual risk of maturing of the unmet

need and getting what may be termed as unplanned for conceptions. Thus unmet need at this stage may indeed be less of an actual threat to fertility regulation as compared to unmet need in the early and middle stages of the reproductive history for wives. Furthermore, these study participants further reveal that disagreement can even occur when contraceptive use desire is the same between husband and wife. Thus the content of communication, the timing and other exogenous factors and not just the occurrence of communication perse are related to communication outcomes in terms of family planning involvement or contraceptive use.

Therefore while the refusal for a permanent method by a woman who is clear about wanting to limit her family size may seem irrational to family planning program service providers, or researchers, this study underlines the significance of seeking answers in the subtle socio-cultural and political economic context that provide the wide context of actors that husbands and wives interact with in forming different motivations for family planning involvement. Fertility regulation behavior is therefore not necessarily directly related to fertility preferences, knowledge or approval of family planning, and examining of the individual as a social being operating in a wide contextual environment and family planning involvement only being a part of that environment opens up other varied possibilities of factors affecting fertility regulation behavior not readily available when this is studied at aggregate levels.

These findings further provide insights regarding spousal family planning communication outcomes. That the disagreement by wives about the use of the permanent method occurred after verbal communication form their husbands for example reveals that fertility regulation

disagreements between husbands and wives indeed may occur as a result of communication, and not necessarily as a result of lack of communication as is often perceived.

This study began with the premise that spousal family planning communication is not a simple process that leads to contraceptive use, but rather is a complex process with the potential for varied outcomes. The natures of communication including non-verbal, indirect, and verbal communication processes are further related to husbands and wives of certain characteristics and reproductive history, and factors and processes that prevail in these reproductive stages to further influence the occurrence, non-occurrence, nature and outcomes of spousal family planning communication during these reproductive stages.

Non-verbal and indirect communication is more commonly related to younger and middle-aged participants, it is often negative and used to reveal husband's negative attitude about contraceptive use by the wife at the time and it often does not lead to contraceptive use. Verbal communication on the other hand is sometimes limited especially when is initiated by the wife or is in the early marriage stages. However, verbal communication from the wife eventually attracts positive contraceptive use perceptions or outcomes for a majority of couples, especially at a later stage. For others, verbal communication from the husband at a later stage especially for purposes of permanent method use attracts contraceptive use but often not for permanent method use.

According to this study, spousal family planning communication has varied results including contraceptive use, delayed use, and non use. This study reveals further insights regarding the content of spousal communication, showing that the majority of husbands fail to communicate

their fertility preferences, even when they actually engage in spousal family planning discussions. It is not always the lack of communication that results in spouses misreporting on their partners' fertility preferences, but the fact that the partners rarely actually talk about fertility preferences, even when they communicate or negotiate contraceptive use. This finding provides further explanation to previous study findings that revealed partners lack of knowledge of spousal fertility preferences.

Numerisation of children, especially prospective ones is generally not a common occurrence among both men and women in the local community. In as much as the idea of family planning has come to be largely accepted, prior decision-making regarding number of family size desired and working towards it is still uncommon among both husbands and wives. For the many husbands in this study therefore, communication about fertility preferences that may not necessarily be complete or clear at early stages of marriage is perceived as potentially giving way to conflict and further undermining his role as dominant decision maker in the household. Yet family planning communication perse, especially when negative outcomes may be carried out.

Similar insights are revealed in the case of communicating contraceptive use approval. While previous studies explained misreporting about spouses attitudes as implication for lack of communication, the findings in this study provide further insights that add onto this knowledge. The findings reveal that especially younger and middle-aged husbands with initial family size use non-verbal and indirect means of communication to communicate negative attitudes about family planning to their spouses, even though they may be holding positive attitudes but wish to

delay contraceptive use. Thus the common assumption that misreporting by couples results form a lack of communication is again refuted here.

Other studies (see Wolff et al., 2000) suggest that disagreements among attitudes about family planning may be more perceived, than real. This study suggests that in some cases, disagreement is based on variations between attitudes held at specific periods versus general attitudes and the varied communication of these at different stages in the couples marriage and reproductive history. The negative—usually time specific—attitudes are communicated through non-verbal and indirect means of communication even when the participants claim to have positive attitudes. This study adds to Chikamata's (1996) question, "approval for whom?" the need to ask, "approval when?" with the understanding that general approval may change in nature during the different stages of marriage.

Recommendations:

- This study's findings reveal the need for family planning programs to improve the nature of the contraceptive knowledge held by men and women. While women receive information through formal clinics and social networks, men in particular need to improve their technical knowledge of how contraceptive methods work, and what their legitimate side effects are—dispelling rumors by involving successful user couples. A more comprehensive understanding of contraceptive methods for both genders is expected to have various positive impacts including the enhancement of spousal family planning communication, an increase in choices regarding the contraceptive methods

available, and a reduction of discontinuation as a result of pressure from the spouse. While increasing a husband's family planning involvement is clearly necessary, caution must be taken considering the potential for an unintended enhancement of male dominance.

- Programs could also benefit from streamlining the existing perception of blanket approval of family planning to address its applicability at the couple and family levels. Presenting evidence of contraceptive use that practically and positively influences one's socio-economic status and spousal relationship is bound to prompt more practical involvement in early contraceptive use and reduce long negotiation periods for couples. Some local clinics have turned to using male CBDs as part of strategies aimed at enhancing positive communication through social networks for men. This study draws attention to the significance of directing the common mass media communication towards a lower level of interpersonal communication, using locally applicable strategies to enhance positive communication and contraceptive use among men in local communities.

In addition to the dispelling of myths and rumors through interpersonal communication, this study underlines the significance of educating both men and women on contraceptive methods' side effects while ensuring the existence of options to enhance choice amongst users based on informed decision making. There is a need to differentiate between side effects and myths and rumors, while offering quality knowledge on individual choice.

This will in turn reduce the skepticism regarding effects on future fertility and enhance contraceptive use for spacing.

- This study also emphasizes the need for programs to further focus on encouraging husbands to communicate fertility preferences to their wives as part of spousal family planning communication as this enhances the negotiation process for contraceptive use and is likely to reduce time period between initial communication and contraceptive use. The enhancement of communication regarding fertility preferences and contraceptive use intentions between spouses is bound to enhance effective verbal communication as majority of participants in this study revealed widespread non-verbal communication related to non consideration or disclosure of individual fertility preferences.

- The challenge therefore is to bring forward effective verbal communication early on in spouses' reproductive and marital life and effectively limit negative non-verbal and indirect communications. Yet spousal family planning communication is situated within socio-cultural environments providing traditional values on spousal relationships and fertility expectations and further within a couples own gendered relationship which influence spousal family planning communication. However, the agency of the individual, the dynamism of culture and the possibilities for enhancing early positive verbal communication cannot be downplayed. This is especially so if linked to enhancements in the understanding of family planning at individual and couple levels through local social networks as explained above; enhancement of understanding of how contraceptive methods work, their side effects and dispelling of myths and rumors; and

lastly actual encouragement of early spousal family planning communication by underlining the significance of fertility preference and contraceptive use intentions communications among younger spouses early on in marriage and empowerment of wives in spousal negotiation and effective communications.

- Regarding future study recommendations, there is a need for more studies that provide qualitative examinations of the many variables that influence contraceptive use such as knowledge, attitudes, and intentions. More studies that appreciate the dynamic nature of these variables and examine variations and implications for contraceptive use will provide a better understanding of the relationship these variables have with contraceptive use among husbands, wives and even men and women in general. More studies that manage to employ both quantitative and qualitative methodology will be uniquely capable of providing valuable insights into elements that require further understanding.

- More in-depth studies of social networks are important in examining or providing further insights into differences between husbands and wives or men and women's social networks and how they impact on contraceptive use. An understanding of the differences in relation to formation of family planning understandings, contraceptive user motivations, dispelling of myths and rumors, and dealing with side effects would serve to enhance their significance in involvement of wives or husbands in effective contraceptive use or family planning involvement.

- The role that wives' social networks could play in influencing both wives and husbands is one area that could be further examined taking into consideration the nature of people involved in the networks, whether they are varied and whether they may have influence on both wives and husbands. The current study reveals for example CBDs though originally appointed by local programs as service providers for women, they play significant roles in influencing husbands and also play significant role in addressing potential male dominance in family planning involvement. The current study revealed that many wives commonly use CBDs as mediators in influencing husband's involvement. The study further reveals various husbands who seek to involve CBDs in situations where the man seeks to get involved and the wife does not want to use contraceptives. While the role of CBDs in enhancing family planning has been previously examined, the current study notes the need to further examine this in light of couple involvement or partnership in family planning.

- Operational research on the enhancement of effective spousal family planning communication processes, focusing on the empowerment of wives and the development of male communication would begin to provide avenues for building a better relationship between the significant variable of spousal communication to actual and timely contraceptive use. Such a study would be both longitudinal and experimental in nature, allowing for comparisons between spouses enrolled in a program from time of marriage, for example, to those who are not—with follow-ups at three or four year intervals.

Despite its revelations and contributions, this study has a number of limitations that, if addressed by future studies, could provide even more insights and further enhance our understanding of couples' family planning involvement.

- This study faced various constraints common to academic research including financial constraints in the field. As a result, the results are limited in terms of the nature of the data applied. The qualitative data is mainly limited to FGDs, and while the FGDs sufficed for the scope of the objectives, other qualitative methods would have lengthened our stay in the field and enhanced the possibility of introducing more varied data. Methodology such as a thorough use of observation is bound to provide other specific findings not necessarily revealed in the FGDs.

- Other design improvements that could be employed by subsequent studies include the enhancement of the application of the quantitative data. The quantitative data as applied in the current study was significant in that it provided a wider distribution of data than the FGDs would have alone, and provided a clear couple comparison analysis for us to examine in the FGDs. However, the KDHS data sample size used in this study was not large enough for the application of more complex quantitative analyses. A subsequent study using quantitative and qualitative couple data would benefit from using a larger quantitative sample size. The limited data set in this study is directly related to the fact that the scope of the study was physically limited to one community in Western Kenya, which in turn limited us to the available couples' data set provided per community from the KDHS. While not applied in the current study, I appreciate the possibility of pooling

DHS data sets from different years (1993, 1998, and 2003) as one way to obtain a sizeable data sample as this would allow for more intense quantitative data analyses.

- This study was also restricted in its application of the conceptual framework, especially looking at specific concepts such as time. A longitudinal study would better capture the time concept from the quantitative data methodology, though for the current study this loss is compensated in the FGD data by the application of the concept of time in terms of participants' marital and reproductive histories in relation to the various findings.

- Given the nature of qualitative data, and its limited applicability to different communities, there is also a need for similar studies in different regions of the country. Such studies would provide significant insights about the similarities or differences in fertility regulation behavior among married couples in different regions in the country. An effective exploration would need to go beyond the usual socio-economic regional differences that are attributed to fertility regulation patterns.

Key questions that are prompted as a result of the current study include:

- Would different communities reveal differences in couple communication processes, or the nature, timing, and outcomes of various spousal family planning communication stages? Given that communication is highly related to local culture, this may seem to be the case. However, such studies would provide clear guidance for family planning programs seeking to address couple partnership in contraceptive use and reproductive health in the country.

- Could social networks be effectively used for the diffusion of effective understandings of family planning, more accurate knowledge of contraceptive methods, and the significance of effective fertility preferences and contraceptive use intention communications early in marriage? Would this then enhance effective spousal family planning communication among younger couples with lower education levels?

- Could male networks be applied in the development of effective family planning perceptions and couple partnership? Susan Watkins and others have done a lot of work on female social networks, and their findings reveal the significance of social networks in enhancement of knowledge, attitudes, and contraceptive use. The current study reveals further that while this is true for women, men seem less influenced by positive interpersonal communications. Given the significance of interpersonal communication and the increased work in this area among women, there is a need to undertake similar initiatives on behalf of male social networks.

- Lastly, given that this study underlines the significant actual and potential role played by CBDs in the enhancement of male involvement in family planning, how do CBDs currently carry out this role? Intense observation and other qualitative methodology could provide data on how family planning program staff and service providers are currently addressing the involvement of husbands and wives, or men and women, as partners in family planning. In this regard, such a study would need to pay close attention to the potential of non-formal service providers to either enhance couple partnership, or male dominance in family planning.