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Male Scepticism, Female Advocacy: Gender Divergence in Family Planning Attitudes in Tarakwa Ward, Uasin Gishu County, Kenya

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ABSTRACT : Background : Kenya has made measurable progress in expanding modern contraceptive coverage and lowering fertility, yet unmet need for family planning (FP) persists unevenly across counties, and rural areas continue to report gendered gaps in contraceptive attitudes and use. This study examined how gender shapes perceptions of, and receptivity to, family planning among men and women of reproductive age in Tarakwa Ward, Uasin Gishu County, Kenya.

Methods: A qualitative, phenomenological and cross-sectional design was used. Thirty-five in-depth interviews were conducted with community members aged 18–49 years, alongside key informant interviews with healthcare providers, using purposive and snowball sampling. Interviews were conducted in Swahili or English, audio-recorded with consent, transcribed verbatim, and analysed in NVivo 12 using Braun and Clarke's (2006) six-step thematic analysis. Findings were interpreted through Bandura's (1986, 1989) Social Cognitive Theory.

Results: Attitudes toward FP diverged sharply by gender. Across 35 community-member interviews, 45.7% expressed active support for FP grounded in maternal health, birth spacing, and financial necessity; 14.3% explicitly framed FP as a "women's issue" from which men could reasonably remain distant; 20.0% expressed male scepticism linked to circulating myths about infertility, diminished virility, and infidelity; and 17.1% described stigma against unmarried FP users as a compounding barrier. Within these themes, individual accounts diverged sharply in content and register by gender: women consistently framed FP in terms of health and economic necessity, while men's accounts more often invoked misinformation, moral concern, or a perceived threat to marital authority. Healthcare providers corroborated these patterns, describing men as largely absent from FP counselling and outreach, and identifying male non-attendance itself as a driver of continued misinformation.

Conclusions: Gender divergence in FP attitudes in Tarakwa Ward reflects socially modelled and reciprocally reinforced roles, consistent with Social Cognitive Theory, rather than differences in knowledge alone. Closing this divergence requires deliberate, male-inclusive engagement strategies that address misinformation directly rather than programming that continues to treat women as the sole audience for FP communication.

KEYWORDS: family planning, gender perceptions, male scepticism, Social Cognitive Theory, sub-Saharan Africa; qualitative research

1. INTRODUCTION

Family planning (FP) is widely recognised as a foundation of maternal health, household economic stability, and national development planning, and modern contraceptive use has expanded across much of East Africa over the past two decades. Yet aggregate progress conceals substantial within-country variation: unmet need for FP remains concentrated in rural, low-income, and structurally underserved communities, where uptake is shaped as much by social and relational dynamics as by the physical availability of methods (World Health Organization, 2025).

A growing body of evidence shows that gender substantially shapes this variation. Across diverse settings, men and women arrive at contraceptive decisions from markedly different positions: women more often frame FP as a health and economic necessity bound up with the demands of childbearing and household management, while men more often regard it as peripheral to their own responsibility, or actively resist it on the basis of misinformation about infertility, infidelity, or diminished authority within the household (Britton et al., 2021; Hamm et al., 2019; Kabagenyi et al., 2016; Reyes, 2020). Where men disengage from, or actively oppose, contraceptive decisions, women frequently resort to covert use, discontinuation, or forgoing FP altogether, outcomes that compromise both reproductive autonomy and continuity of care (Sundararajan et al., 2019). Young and unmarried women face a distinct, compounding set of barriers, often navigating both partner disapproval and community-level judgement when seeking contraceptive services (Ochako et al., 2015).

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Tarakwa Ward, a rural agricultural community in Kesses Sub-County, Uasin Gishu County, presents a case in point. Despite the presence of fourteen health facilities offering FP services, uptake of modern contraceptive methods in the ward remains below the national average (Ministry of Health, 2017), a gap attributed in the parent study to cultural resistance, limited awareness, gendered decision-making norms, and periodic contraceptive stockouts. This article draws on qualitative data from that study to examine, specifically, how gender structures divergent attitudes toward FP in Tarakwa Ward: why women emerge as the community's primary advocates for contraception, why men remain sceptical or disengaged, and what this divergence implies for FP programming in similar rural Kenyan settings.

The article addresses one central question: *how, and why, do men's and women's attitudes toward family planning diverge in Tarakwa Ward, and what social mechanisms sustain that divergence?*

2. THEORETICAL FRAMEWORK

The study is anchored in Bandura's (1986, 1989) Social Cognitive Theory (SCT), which conceptualises human behaviour as the product of dynamic, reciprocal interaction among personal, behavioural, and environmental influences. Central to SCT is the concept of observational learning: individuals acquire beliefs and behavioural scripts by observing the attitudes and actions of peers, elders, religious leaders, and other socially credible models, in addition to through direct experience. Applied to contraceptive behaviour, SCT suggests that FP attitudes are rarely formed in isolation; rather, they are modelled and reinforced through community narratives, spousal relationships, and the visible behaviour of respected figures within the social environment.

This framework offers analytical purchase on gender divergence in FP attitudes specifically because it treats male disengagement and female advocacy as learned, reciprocally reinforced roles rather than fixed dispositional traits. Men who observe peers treating FP as "women's business" are more likely to adopt the same posture; women who observe other women bearing the practical and reputational costs of pregnancy are more likely to internalise contraception as a personal responsibility. Where negative narratives about FP (fears of infertility, moral decline, or infidelity) circulate widely and are not contested by credible counter-models, individuals may act on those narratives even where they have accurate information about contraceptive methods. Awareness alone is therefore an insufficient lever for behaviour change.

SCT was selected over alternative frameworks such as Connell's (1987) Theory of Gender and Power because the study's primary aim was to characterise how contraceptive attitudes are acquired and transmitted within the community's everyday social environment, rather than to map the structural and economic power asymmetries underlying household bargaining over contraception. SCT's emphasis on observational learning and reciprocal determinism offers direct analytical purchase on the mechanism identified in Section 4.2, where a minority of men's attitudes shifted in response to proximate observation of a household member's health crisis rather than in response to new health information. A structural, power-centred framework remains a valuable complementary lens, particularly for explaining why male disengagement may persist even where it is materially advantageous to men; this alternative reading is considered further in the Discussion.

3. METHODS

3.1 Design and Setting

The study used a qualitative, phenomenological, and cross-sectional design to explore the lived experiences and meanings that men and women in Tarakwa Ward attach to family planning, with data collection conducted between January and June 2023. The phenomenological approach was chosen to prioritise participants' own interpretations of their reproductive decisions over externally imposed categories. Tarakwa Ward, part of Kesses Sub-County in Uasin Gishu County, is a predominantly agricultural community of approximately 47,683 residents (Kenya National Bureau of Statistics, 2019), served by fourteen health facilities including a sub-county hospital, dispensaries, health centres, and private clinics.

3.2 Sampling and Participants

A combination of purposive and snowball sampling was used to recruit two respondent groups: community members aged 18–49 years, and healthcare providers involved in FP service delivery. Purposive sampling, supported by health workers and community leaders, targeted individuals with relevant knowledge or lived experience of FP; snowball sampling was then used to reach harder-to-access groups, notably adolescent mothers and unmarried women. Consistent with saturation-based purposive sampling, no fixed a priori recruitment target was set for either group; data collection continued until no new themes emerged, yielding 35 in-depth interviews (IDIs) with community members, of whom 71% were female and 29% male, and 9 key informant interviews (KIIs) with healthcare providers, drawn from nine of the ward's fourteen health facilities.

3.3 Data Collection

Data were collected through semi-structured interviews conducted in Swahili or English according to participant preference, each lasting 45–60 minutes. Interview guides, piloted with five individuals in the neighbouring Ainabkoi Ward, were iteratively revised toward more open-ended phrasing to improve cultural relevance and depth of response. All interviews were audio-recorded with consent and supplemented with field notes capturing non-verbal cues and contextual observations. Interviews conducted in Swahili were translated into English by the first author, who conducted all interviews personally.

3.4 Data Analysis

Data were managed in NVivo 12 and analysed thematically following Braun and Clarke's (2006) six-step framework: familiarisation, initial coding, theme generation, theme review, theme definition, and reporting. Open coding identified concepts such as "partner influence," "misconceptions," and "gendered responsibility," which were refined through axial coding into the gender-perception themes reported below. The four perception categories reported in Table 1 are independent thematic codes rather than mutually exclusive response options, so a single interview could be coded under more than one category, or under none; frequencies are therefore reported as a proportion of all 35 community-member interviews (N = 35) and are not expected to sum to 100%. These frequencies are descriptive counts characterising pattern prevalence within this purposive sample and are not intended to support statistical generalisation beyond the study sample.

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3.5 Trustworthiness

Several procedures supported the trustworthiness of the analysis. Transcription and translation fidelity was independently cross-checked by a trained research assistant, who reviewed transcripts against the original audio recordings; the supervisory team separately reviewed translated transcripts against the analytic write-up to verify that reported findings remained faithful to participants' original wording and meaning. To support interpretive validity, summary notes and coded excerpts were shared with a subset of participants, who were asked whether the analysis accurately reflected their views; feedback was documented, including instances in which participants confirmed or corrected the researcher's interpretation. This combination of independent transcript-fidelity checking, supervisory review, and member checking (Lincoln & Guba, 1985) provides converging, though not identical, assurance to formal back-translation, which was not separately performed.

3.6 Ethical Considerations

Ethical approval was obtained from the National Commission for Science, Technology and Innovation (NACOSTI; reference NACOSTI/P/22/15764), the Moi University Institutional Research and Ethics Committee, and Uasin Gishu County health authorities. Written informed consent was obtained from all participants; participation was voluntary, and confidentiality was protected through pseudonymisation and secure, password-protected storage of recordings and transcripts. No financial or material incentives were offered, consistent with the Declaration of Helsinki's guidance on avoiding undue inducement in research involving human participants (World Medical Association, 2013).

3.7 Reflexivity

The first author conducted all interviews personally and, as a male Kenyan researcher affiliated with Moi University rather than with any of the health facilities studied, occupied a position that plausibly shaped both access and disclosure. Being male may have constrained some women's willingness to discuss intimate contraceptive experiences candidly, particularly around side effects and spousal conflict; conversely, it may have facilitated candour among male participants discussing scepticism or resistance to FP, since such disclosures did not require justification to a female interviewer. The researcher's university affiliation, rather than a facility-based one, was disclosed to participants at the outset of each interview to distinguish the study from routine clinical service delivery and to reduce social-desirability pressure toward favourable reporting of clinic-based FP services. Field notes documenting participant hesitancy or apparent discomfort were reviewed during analysis to avoid over-interpreting guarded responses as straightforwardly attitudinal.

4. RESULTS

Thematic analysis of the 35 community-member interviews revealed a consistent and pronounced gender divergence in attitudes toward FP, summarised in Table 1.

Table 1: Gender-Patterned Perceptions of Family Planning in Tarakwa Ward (N = 35)

Perception Category	n	%
FP viewed as “women's responsibility”	5	14.3%
Women advocate FP for health & financial reasons	16	45.7%
Male scepticism linked to FP myths	7	20.0%
Stigma against unmarried FP users	6	17.1%

4.1 Women's Advocacy: Family Planning as Health and Economic Necessity

Among female participants, FP was consistently framed not as an abstract health choice but as a practical response to the material demands of childbearing and household management. A 35-year-old tailor explained:

> *“Women support it because they are the ones who deal with pregnancy and raising children. But some men think it is unnecessary or that it will make women barren.”*

This statement is characteristic of a broader pattern in the data: women's advocacy for FP was grounded in the gendered distribution of reproductive labour, whereby women bear primary responsibility for both fertility outcomes and caregiving, and consequently experience FP as a means of managing that burden rather than as a discretionary lifestyle choice.

For women navigating economic precarity, this framing was sharpened further. A 32-year-old vegetable vendor described FP explicitly in terms of financial resilience:

> *“Most women support it, especially those who are struggling financially. But men often think it is a way for women to cheat without consequences.”*

The juxtaposition in this account, women's economic reasoning set against men's suspicion of infidelity, captures the interpretive gulf separating the two groups: the same behaviour (contraceptive use) is read by women as prudent household management and by men as a threat to marital control. Healthcare providers corroborated this asymmetry, reporting that financial strain reliably pushed women toward FP services, while men's engagement remained shaped chiefly by cultural expectation and unfounded fears of promiscuity, a pattern consistent with earlier qualitative work in Tanzania showing that couples' FP negotiations are structured around gendered assumptions about fidelity and control rather than shared health reasoning (Mosha et al., 2013).

4.2 Male Scepticism: Misinformation, Moral Concern, and Perceived Loss of Authority

Male participants' accounts diverged from women's in both content and register. Where women spoke of FP in terms of managing tangible burdens, men more often invoked generalised, second-hand concerns about health risk and morality. One male respondent stated plainly:

> *“Some men still think it is bad for women's health. They strongly oppose it.”*

Such statements reflect a form of paternalistic reasoning in which male opposition is legitimised through a professed concern for women's health, even where that concern is untethered from clinical evidence. Several women reported that this scepticism translated directly into spousal pressure to discontinue contraceptive use, compounding the physical side effects that already accompany some methods. A 38-year-old tailor recounted:

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> *"I tried the injection, but it made me bleed a lot. My husband also complained that it was affecting my mood, so I stopped using it."*

This account illustrates how discontinuation in Tarakwa Ward is rarely attributable to side effects alone; rather, side effects become the occasion through which spousal disapproval is exercised, with husbands attributing behavioural or emotional changes to contraception and using this attribution to press for its cessation. Healthcare providers confirmed this pattern, noting that male partners frequently held FP responsible for changes in mood or health that may have had other causes, and that some men refused outright to permit continued use on the basis of myths about lasting reproductive harm.

Notably, misinformation was not confined to married men's objections to their wives' contraceptive use; it also structured the treatment of unmarried women seeking FP independently. A 26-year-old casual labourer described this compounding stigma:

> *"Family planning is seen as more acceptable for women with children. But for young, unmarried girls like me, people think it is wrong to use it. They say it encourages bad behaviour and future health complications."*

A 19-year-old student's account of an actual clinic visit illustrates that this stigma is enacted at the point of service as well as in community talk:

> *"When I went to the clinic, the nurse asked me if I was married. I felt ashamed and left without getting any information. If there was a youth-friendly space, I would have stayed and asked questions."*

This account signals that gender divergence in FP attitudes is cross-cut by marital status: FP is judged socially acceptable primarily insofar as it is exercised by married women in service of household stability, while its use by unmarried women is read as a moral transgression rather than a legitimate health decision. Providers observed that this stigma pushed unmarried women toward discreet, infrequent-visit methods such as injectables, precisely to avoid the surveillance that public clinic attendance invited. This coping strategy mirrors the covert-use patterns documented among young, unmarried women elsewhere in Kenya, where fear of being seen at a clinic was itself a primary deterrent to care-seeking (Ochako et al., 2015).

Male scepticism in Tarakwa Ward was not, however, uniformly static. A minority of male participants described a shift in their own position, typically prompted by directly witnessing the consequences of unmanaged fertility within their own household. A 44-year-old married man reflected:

> *"As men, we are told that family planning weakens women. I resisted at first, but later I saw my wife was exhausted from pregnancies. It is hard to change what elders taught us, but I am beginning to see the benefits."*

A second account, from a 39-year-old married man, located a similar shift in a health crisis experienced by a female relative rather than a spouse:

> *"I used to believe that family planning was a way for women to misbehave. But when I saw my sister nearly die from complications of too many births, I realized it is necessary. Still, many men in my age group refuse to accept this truth."*

These two accounts matter analytically because they show the mechanism of change operating in the same register as the mechanism of resistance: both are triggered by direct or proximate observation, not by abstract health information. Neither man reported that a clinic pamphlet or radio advertisement altered his view; both located their shift in witnessing a woman close to them bear the physical cost of non-use. This is consistent with an observational-learning account of attitude change, and it directly foreshadows the theoretical interpretation developed below.

Healthcare providers' own framing of the problem converged strikingly with this pattern. A male clinical officer offered what is arguably the clearest statement of the male-engagement gap from the provider side:

> *"As a male clinical officer, I notice men rarely accompany their wives. If they did, they would hear the explanations directly and stop spreading misinformation. Male involvement is the missing link."*

4.3 Interpreting the Divergence: A Social Cognitive Reading

Read through Bandura's Social Cognitive Theory, the divergence documented here is best understood not as two independent sets of individual beliefs but as a single, reciprocally reinforced social system. Men in Tarakwa Ward learn disengagement by observing peers, elders, and community institutions that consistently code FP as outside the male domain; this observational learning is reinforced whenever male scepticism goes unchallenged in public discourse. Women, correspondingly, learn to treat contraceptive decision-making as their sole responsibility, but within boundaries constrained by the need for secrecy, the risk of spousal disapproval, and dependence on partner tolerance rather than active partner support. The minority of men who described shifting their own position (Section 4.2) offer a particularly direct illustration of the theory's central mechanism: both men located their change not in receiving new information, but in directly observing a wife or a sister bear the physical cost of unmanaged fertility. This is vicarious, consequence-driven learning in precisely the form SCT predicts, and it suggests that the same mechanism sustaining male disengagement (observation of a norm) is also the mechanism most likely to unsettle it, provided the community makes alternative, engaged models visible rather than exceptional.

This reading is consistent with comparative evidence from Western Kenya, where women's covert contraceptive use in response to partner resistance reflects the same underlying dynamic (Britton et al., 2021), and with research among low-income men elsewhere, whose discomfort discussing FP was traced to an entrenched belief that reproductive decisions belong to women alone (Hamm et al., 2019). It also parallels findings from rural Mexico, where male household authority routinely overrode women's contraceptive preferences, forcing women either to abandon FP or to negotiate its use carefully around male approval (Reyes, 2020); from rural Uganda, where socio-cultural inhibitions rather than lack of knowledge best explained low modern contraceptive uptake (Kabagenyi et al., 2016); and a broader meta-synthesis across low- and middle-income countries showing that sociocultural norms consistently position FP as a woman's duty while relegating men to marginal, supervisory roles (Roudsari et al., 2023). At the national level, this pattern is echoed in Kenya's own population policy diagnostics, which have repeatedly identified low male involvement in reproductive health decision-making as a persistent structural barrier to FP uptake (National Council for Population and Development, 2020). The critical implication of the SCT lens is that awareness campaigns targeted solely at increasing individual knowledge are unlikely to shift this pattern on their own: because the divergence is socially modelled and mutually reinforced, durable change requires altering

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what the community publicly validates: making male engagement in FP visible and socially rewarded, rather than treating men's absence from FP decisions as a neutral default.

5. DISCUSSION

This study set out to characterise how gender structures divergent attitudes toward FP in a rural Kenyan ward, and to interpret that divergence theoretically. Three findings warrant particular emphasis. First, the divergence is substantial and patterned rather than incidental: women's advocacy clustered consistently around health and economic necessity, while men's scepticism clustered around misinformation and a perceived threat to marital authority. Second, marital status functioned as a second axis of exclusion layered onto gender, such that unmarried women's FP use was doubly contested: first as a matter man felt entitled to resist, and second as a matter the wider community deemed morally inappropriate outside marriage. Third, healthcare providers' own accounts suggest that service delivery has, to date, largely accommodated rather than challenged this divergence: FP outreach in Tarakwa Ward is described as women-oriented by default, which may inadvertently entrench the very disengagement that undermines shared contraceptive decision-making.

These findings sit within a wider regional literature documenting persistent male disengagement from FP across sub-Saharan Africa and beyond, and they reinforce a point increasingly made in that literature: that gender-transformative FP programming cannot succeed through supply-side fixes (commodity availability, clinic hours) alone if the underlying social scripts around who "owns" contraceptive decisions remain unaddressed. Programmatically, this suggests three concrete directions. First, male-inclusive education should be designed not as a generic add-on but as a direct rebuttal of the specific myths identified here (infertility, diminished virility, and infidelity) delivered through credible male messengers (community elders, peer leaders, male healthcare workers) capable of modelling a different norm, consistent with the observational-learning mechanism central to SCT. A small-scale, community-based intervention targeting masculine norms tied to contraceptive resistance among partnered men in western Kenya offers a directly relevant, evaluated model for this approach: participation was associated with measurable gains in contraceptive acceptance, contraceptive knowledge, and willingness to discuss contraception with a partner (Newmann et al., 2023), suggesting that norm-focused, male-targeted programming of the kind indicated by the present findings is both feasible and testable in comparable rural Kenyan settings. Second, counselling protocols should anticipate that side effects will often become a site of spousal contestation, and should equip women with clear, portable explanations they can use in that negotiation. Third, discreet and youth-friendly service options should be preserved and expanded for unmarried women, whose access needs differ qualitatively from those of married women and are not well served by outreach models built around household or spousal engagement.

It is also worth situating the theoretical framework used here against an alternative reading. Social Cognitive Theory, as an individual-learning framework, is well suited to explaining how contraceptive attitudes are transmitted and how they could in principle be shifted, but it is less well suited to explaining why male disengagement persists despite the costs it visibly imposes on women within the same households. A structural account such as Connell's (1987) Theory of Gender and Power would foreground the material and relational advantages that male disengagement confers, including retained household authority and reduced domestic negotiation, and would locate intervention targets in bargaining power and resource control rather than solely in observational modelling. The two readings are complementary rather than competing: SCT explains the mechanism by which norms are transmitted and could shift, as illustrated by the men in Section 4.2 who changed position after direct observation; a power-centred account better explains why other men's disengagement, being materially convenient, may prove considerably more resistant to the same observational pressure.

6. LIMITATIONS

Several limitations bear on the interpretation of these findings. The purposive and snowball sampling strategy, while well suited to a phenomenological design, does not support statistical generalisation to Tarakwa Ward as a whole or to other rural Kenyan settings; the frequencies reported in Table 1 describe pattern prevalence within this specific sample and should not be read as population estimates. The gender composition of the community-member sample (71% female) reflects women's greater willingness to engage with a study on FP and may itself be a data point about differential engagement rather than solely a sampling artefact, but it also means men's perspectives are represented by a comparatively small number of interviews.

7. CONCLUSION

In Tarakwa Ward, family planning is not perceived through a single, shared community lens but through two substantially divergent gendered lenses: women predominantly experience FP as a necessary tool for managing health and economic pressures, while men predominantly experience it as someone else's concern, when they do not actively contest it on the basis of misinformation. Understood through Social Cognitive Theory, this divergence is a learned and socially sustained pattern rather than a fixed cultural fact, which means it is, in principle, amenable to change through deliberate reshaping of the social models and narratives that communities are exposed to. Closing the gap will require FP programming that treats male engagement as a core design objective rather than an optional supplement, alongside continued attention to the distinct, compounding barriers faced by unmarried women.

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