




REPUBLIC OF KENYA

2014 National Survey on

MALE INVOLVEMENT

in Family Planning and
Reproductive Health
in Kenya





All rights reserved. This publication has been made possible by the Government of Kenya and the National Council for Population and Development. Any part of this document may be quoted provided the source is acknowledged. It may not be sold or used in conjunction with commercial purposes for profit. The contents are the responsibility of the National Council for Population and Development.

2014 National Survey on
**Male Involvement in
Family Planning and Reproductive Health
in Kenya**



National Council for Population
and Development

November 2014



Foreword



The 2014 National Survey on Male Involvement in Family Planning and Reproductive Health was carried out to provide empirical and current information to policy makers, planners, researchers, and programme managers on the underlining factors for low male involvement in Family Planning and Reproductive Health in Kenya.

Specifically, the survey collected data on; community members' knowledge of family planning and reproductive health, their attitude and beliefs towards family planning and reproductive health, the extent of male involvement in family planning and reproductive health, and barriers to men's involvement in family planning and reproductive health. The survey also examined the existing policy and programme responses to male involvement with a view to generating pragmatic recommendations to enhance male involvement.

Data were collected using various qualitative data collection techniques. The main data collection methods used included; focus group discussions (FGDs), key informant interviews (KIIs), exit interviews and narratives. The FGDs were conducted among married men aged 15-24 years and 25-54 years, married women aged 15-24 years and 25-49 years. Additionally, FGDs were also conducted with a mix of married men and women aged 15-24 years, and a mix of men and women aged 25-54 years. Separate discussions groups were also conducted among persons with disability. Information was also obtained from service providers in sampled health facilities, observations were made in the selected facilities, exit interviews were conducted with males who had visited facilities on the day of the survey; in-depth interviews were held with county directors of health and with selected community leaders.

The report presents key findings of the survey and some recommendations to address the observed low level of male involvement in Family Planning and Reproductive Health in Kenya. This information is expected to guide the planning, implementation, monitoring and evaluation of population and health initiatives in Kenya. It is the responsibility of every stakeholder to play their part so that all men can be fully involved in matters of family planning and reproductive health for national development. Let us not have the low involvement of men as a continuing challenge during future review of the Population Policy for National Development. It is our collective responsibility to ensure that this vision is achieved.

A handwritten signature in black ink, appearing to read 'Anne Waiguru'.

Anne Waiguru, OGW
Cabinet Secretary
Ministry of Devolution and Planning

Preface



There exists a great opportunity in Kenya for further increase in Contraceptive Prevalence Rate from 46 per cent recorded during the KDHS 2008/09. However, this increase can only be achieved by improving the level of male involvement in family planning and reproductive health which is generally very low. Family planning has traditionally been perceived as a woman's affair. Despite the continued commitment by the government to the promotion and provision of Family planning and reproductive health services, low male involvement is one of the key compounding factors that impede the demand for and utilization of these services.

It is in this context that this survey was designed to collect information that would contribute to the understanding of the role of men in family planning and reproductive health in Kenya.

The survey covered all the 47 counties, with the selection guided by the National Sample Survey and Evaluation Programme (NASSEP) IV clusters selected for the 2014 Kenya Demographic and Health Survey (KDHS). It targeted both young and adult males and females. This was a qualitative survey which explored community members' knowledge on Family planning and reproductive health, their attitudes and beliefs towards Family planning and reproductive health, sources of information, role of men in family planning and reproductive health, barriers to male involvement in family planning and reproductive health and the existing policy and program responses to male involvement in Family planning and reproductive health.

The results of this survey showed that there is inadequate and incorrect information regarding family planning and reproductive health services among men and women in Kenya. There is therefore a need for continuous education to address the prevailing misconceptions on the utilization of family planning and reproductive health services in Kenya. These results will be shared with stakeholders and it is expected that this will guide programming for FP/RH services to support the participation of men as equal partners.

Eng. Peter Mangiti
Principal Secretary
Ministry of Devolution and Planning

Acknowledgement



The Kenya National Survey on Male Involvement in Family Planning and Reproductive Health 2014 collected qualitative data from all the forty seven counties in Kenya with a view to assess: community members' knowledge of family planning and reproductive health, community members' attitudes and beliefs towards family planning and reproductive health, the extent to which men are involved in family planning and reproductive

health issues, identify barriers to men's involvement, establish the existing policy and programme responses to male involvement in family planning and reproductive health and suggest pragmatic recommendations for enhancing men's involvement in FP/RH in Kenya.

This survey benefited from wide consultations with individuals, institutions and organizations with special interest in family planning and reproductive health. Their participation, assistance, comments, suggestions and cooperation in providing information to the process proved invaluable.

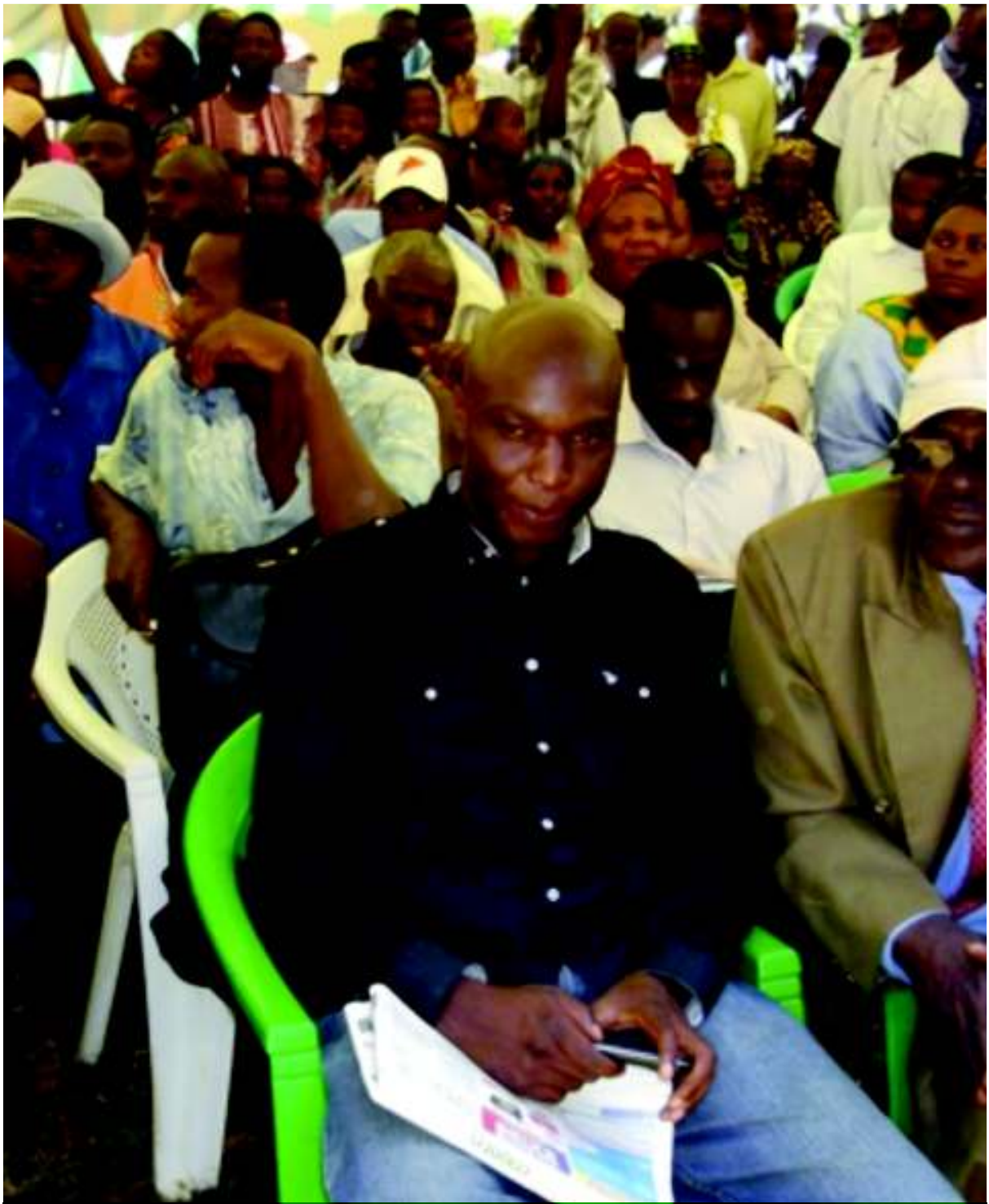
The National Council for Population and Development (NCPD) wishes to acknowledge the dedicated efforts of the institutions that made special contribution to the success of the survey by nominating technical officers to serve in various oversight committees. These include the Kenya National Bureau of Statistics, the Department of Gender, Ministry of Health, the Population Council, the Family Health Options Kenya (FHOK), Family Health International 360, the Population Studies and Research Institute and the School of Public Health, University of Nairobi.

I am grateful to Professor Joyce Olenja from the School of Public Health, University of Nairobi, for providing technical guidance to the entire research process.

Special appreciation also goes to Dr. Bartilol Kigen and Mrs. Fatuma Dubow (Ministry of Health), Ms Jackline Kivunaga (Population Council), Ms Irene Muhunzu (FHOK), Mr. Stephen Macharia (UNFPA), Ms. Catherine Muoki and Ms Eunice Njoki (Department of Gender), Mr. Samuel Ogolla (Kenya National Bureau of Statistics), Professor Lawrence Ikamari (PSRI) and Dr. M. Solomon (FHI 360) for working tirelessly with the technical officers of the Council to ensure the project was a success. I wish to acknowledge the contribution of Debbie Gachuki and Pamela Onduso of Pathfinder International for their facilitation role during the field work. Last but not least I wish to thank the entire staff of the Council under the leadership of Mr. George Kichamu (Director Technical Services), Ms. Margaret Muthoni Mwangi (Director Corporate Services) and Ms. Vane Lumumba (Deputy Director, Policy and Research). I also wish to recognize Mr. John Anampiu (ADP-Research), Mr. Francis Kundu (ADP-Policy), Mr. Nzomo Mulatya (Deputy Director, Programme Coordination, Monitoring and Evaluation), Mr. Alex Juma (ADP-CAPE), Ms. Catherine Ndei (ADP-Partnership), Faith Ogolah (Research), Mr. Reinhard Rutto (M&E), Mr. David Kinyua (PRO), Enoch Obuolo (Policy), Mr. Peter Nyakwara, Mr. Charles Oisebe, Ms. Catherine Ndei, Mr. Seth Omondi, Ms. Lucy Kimondo, Ms. Taslim Wasom, Mr. William Ochola, Ms. Dorothy Oliech, Mr. Maurice Opiyo, Ms. Lorna Gathua, and Mr. Sam Kingoo for their dedicated effort throughout the entire research process. I sincerely appreciate the field supervision work done by the County Population Coordinators across the thirteen survey regions. Finally I cannot forget to thank all the participants who gave their time in responding to the questions that have made this report so rich in views and information.



Dr. Josephine Kibaru-Mbae
Director General
National Council for Population and Development



Executive Summary

Executive Summary

Background

Access and uptake of family planning methods enables individuals and couples to plan for and attain their desired number of children as well as determine the spacing and timing of births. In so doing, they are better able to save resources, increase their household income, invest in their children and plan their lives better.

Family planning is one of the most cost-effective ways of improving health and increasing quality of life. Unfortunately, only 26 percent of currently married women of reproductive age in Kenya who would like to space or limit their births are missing out on these benefits because they are not using any form of family planning method.

Although recent findings show an increase in the contraceptive prevalence rate from 39 percent (KDHS, 2003) to 46 percent (KDHS, 2008), the total fertility rate is still high and has stagnated for a decade (4.6 in 1998, 4.7 in 2009). Despite the continued commitment by the government to the promotion and provision of family planning and reproductive health services, low male involvement is one of the key compounding factors that impede the demand for and utilization of FP/RH services. It is within this context that this survey was designed to collect information that would contribute to the understanding of male involvement in family planning and reproductive health in Kenya.

Objectives of the Survey

The survey specifically sought to assess: community member's knowledge on family planning and reproductive health, their attitude and beliefs towards family planning and reproductive health, and the extent to which men aged 15-54 years are involved in family planning and reproductive health. It further sought to identify barriers to men's involvement in family planning and reproductive health, establish the existing policy and programme responses to male involvement in family planning and reproductive health and generate pragmatic recommendations for enhancing men's involvement.

Survey Methodology

The survey used qualitative methods of data collection and analysis. These included; focus group discussions, key informant interviews, in-depth Interviews, health facility exit interviews and narratives. Focus group discussion data was collected from married men aged 15-24 years and 25-54 years, married women aged 15-24 years and 25-49 years in the thirteen cluster regions*. Although the survey focused more on homogenous groups, mixed groups of both sex categories were also conducted. To gather further insights into issues and dynamics of male involvement in FP/RH, interviews were also conducted with community leaders, policy makers and health facility in-charges. The study tools were pre-tested before the survey. The survey used the NASSEP IV KDHS clusters in the selection of the thirteen cluster regions. After transcription, NVIVO (V10) software was used in processing and analyzing the qualitative data.

*See Kenya Map with the survey distribution of counties by cluster on Page 3

Summary of findings

Highlights of the key findings and subsequent recommendations of the survey include the following:

I. Knowledge and Understanding of Family Planning and Reproductive Health

a. Knowledge of family planning methods

All respondents mentioned a wide range of FP methods including modern and traditional methods. Traditional methods were more widely mentioned in the rural and hard to reach areas compared to urban settings.

b. Understanding of family planning

Most respondents have a good understanding of family planning. Young adults in urban regions demonstrated a better understanding. Respondents mainly stated that family planning involves the spacing, delaying as well as limiting the number of children.

c. Benefits of family planning

A large number of respondents perceived family planning to be beneficial in safeguarding the health of the mother and the child, economic wellbeing of the family, community, and the country at large.

d. Condom use and Vasectomy

The only two family planning methods available for men; condom and vasectomy are not popular amongst men in most of the communities because their spouses are opposed to their use.

e. Family Planning and population size

Family planning assumed a political dimension in certain communities. Some participants felt that family planning would result into further political marginalization on account of their smaller numbers. They therefore felt that although family planning is good it is for others and not for communities that have small population size.

2. Perception and attitude towards family planning and reproductive health

Findings from the survey show mixed reactions on male involvement in FP/RH stemming from their experience with the use of FP methods, myths and misconceptions, cultural norms and religious beliefs.

a. Positive perception of male involvement in FP/RH

On a more positive note there is increased awareness on the need for male involvement in FP/RH particularly among the younger respondents owing to the pressing challenge of land in rural regions and economic hardship in the urban areas.

Practice of birth spacing by religious communities is acceptable and supported by men. This presents an opportunity to target them with information that proper use of modern family planning methods will help in achieving the desired birth spacing.

In certain regions, there is an increased level of understanding of the benefits of family planning and the participants expressed positive views. This was as a result of certain programme interventions that have used the approach of male family planning champions to promote male involvement.

b. Negative perception of male involvement in FP/RH

Health concerns, Myths and Misconceptions about FP

Health concerns

The negative attitude towards family planning among men was based on the view that the use of FP methods causes excessive bleeding, swelling of legs, weight gain among women.

Myths and Misconceptions about FP

Majority of those who were opposed to use of FP methods believed that it causes infertility, cancer and low libido in women.

Role of Culture and Religion

- Cultural gender norms support the notion that the care of young children and use of contraception is the sole responsibility of women; men therefore fear to be involved because they will be seen as disempowered.
- Islam and Christian teachings opposes the use of permanent FP methods but support birth spacing and the use of natural methods. These teachings offer an opportunity to build support around birth spacing.

3. Sources of Information on Family Planning and Reproductive Health

- a. Radio and friends are a common source of Family Planning information for a large number of men.
- b. Men hardly go to health facilities for FP information and services due to stigma.
- c. Wives are an important source of FP and MCH information.
- d. Mass media and spouses are the most preferred sources of MCH information for men.
- e. Men fear going to the health facilities with their pregnant wives due to fear of HIV tests and long waiting time.

4. Role of Men in Family Planning and Reproductive Health

The results obtained from this study show low male involvement in FP/RH. This is mainly due to the stigma associated with FP and MCH being perceived as a woman's issue. Men played the following roles:

- a. In most of the regions men were more actively involved in maternal and child health in terms of ensuring good nutrition and access to health services.
- b. Majority of men supported FP/RH through providing financial support or transport to their spouses.
- c. Men in some regions also allowed and encouraged their wives to use FP/RH services.

5. Barriers to men's involvement in family planning and reproductive health

The barriers to male involvement in FP/RH are categorized as follows:

i. Individual Barriers to Male Involvement

- a. Inadequate and incorrect Information and Knowledge on FP/MCH was reported as a major barrier to male involvement.
- b. Health concerns and Myths and Misconception on certain methods of family planning.

The use of FP methods causes health complications, infertility, low libido among women. As a result of these;

- Some women are therefore discouraged by their spouses not to use the FP methods.
 - Some men believe that use of FP methods by their spouses promotes promiscuity.
 - Some men therefore discourage their spouses from using family planning methods.
- c. Poor spousal communication is a key deterrent to male involvement in almost all regions. The only two methods available for men; condom and vasectomy are less commonly used due to poor spousal communication and objections by some wives.
 - d. Alcoholism and absentee husbands was mentioned as a key contributing factor.
 - e. Low male participation according to some women respondents in some regions is also influenced by opposition from male peers and mothers-in-law.
 - f. Majority of young people, particularly men, reported a general lack of mentors or role models in FP/RH.

ii. Community Barriers

- a. Cultural values such as the desire for more children, sex preference for male child, and survival of children were reported mostly in rural areas as barriers that stifle male involvement in FP/MCH.
- b. Care giving, household chores and family planning are strongly guided by the gender norms in majority of the communities.
- c. Religion and traditional beliefs were mentioned across the regions as barriers to male involvement in FP/RH.

iii. Health Service Barriers

- a. Inadequate male FP/MCH Service Providers at health facilities is a key limitation to male participation. Men are reluctant to be served by female service providers.
- b. Slow service provision and long waiting hours at service delivery points are impediments to male involvement.
- c. Unfriendly service providers are not supportive of male engagement.
- d. Inadequate supply of FP Commodities and essential drugs in health facilities creates dissatisfaction and hinders male engagement in FP/MCH.
- e. Health facility design layout (waiting area, counselling space) is not conducive to male involvement. There is hardly any privacy and the service area is usually crowded with mothers and children.
- f. Limited FP method mix for couples in most facilities.
- g. Human resource shortage and lack of skills at the facility level are among the main constraining factors affecting FP and RH service provision.

iv. Policy Barriers

- a. The FP and RH policies and strategies being implemented at the County level are those that were developed at the National level, without proper dissemination.
- b. Strategies for Male Involvement have not been explicitly incorporated in the County Strategic Plans.
- c. Awareness of FP and RH policies is generally low among service providers especially in the private sector.
- d. Lack of a multi-sectoral approach to male involvement.

Other challenges stifling the role of men are mentioned in detail in the section on barriers in this report.

Recommendations

Recommendations for enhancing male involvement in FP/RH

- a. Address the knowledge and information gap among men in FP/RH by educating and sensitizing men on importance of FP/RH services to inform their health concerns and demystify myths and misconceptions about FP.
- b. Use of innovative FP communication approaches targeting men involvement in FP/RH particularly in areas where cultural and religious practices are prevalent. Emphasis should be placed on good birth spacing and use of FP as efforts of promoting health for individuals and the community.
- c. Use of men as change agents, also referred to as FP champions in FP/RH is reported to be a successful approach that has the potential to promote male involvement.
- d. Use of mass media to disseminate adequate information on FP methods particularly the less popular methods should be explored fully.
- e. Popularize the two contraceptive methods available to men; condoms and vasectomy as effective FP methods. They have been noted to be unpopular because many women and men are opposed to them for fear of mistrust in marriage. Couples who are using these methods should be trained and used in sensitization forums.
- f. Development of county specific policy/strategy/guidelines on male involvement in FP/RH programmes/services should be strategically applied.
- g. Sensitize health workers on the existing health policies and strategies including those on FP and RH.
- h. Increase the number of male service providers trained on the provision of quality FP/RH services.
- i. Allocation of more resources by county government for provision of male-friendly FP/RH services.
- j. Involvement of more male health workers as community health workers in the provision of FP/RH services would contribute to enhancing men's access to these services.
- k. Skills update and refresher training for more health workers especially in the lower level health facilities. This should be done alongside the recruitment of more health workers to alleviate the existing shortages.

Table of Contents

Foreword	iii
Preface	v
Acknowledgement	vi
Executive Summary	ix
Background	ix
Objectives of the Survey	ix
Survey Methodology	ix
Summary of findings	x
Abbreviations	xvii
Chapter One: Background	I
1.1 Objectives of the Survey	2
1.2 Survey Organization	2
1.3 Sample Design	2
1.4 Survey population	4
1.5 Data Collection Tools	5
1.6 Recruitment and Training	6
1.7 Field Work	7
1.8 Data Processing and Analysis	7
Chapter Two: Knowledge and understanding of family planning and maternal and child health	9
2.1 Understanding and Knowledge of Family Planning	9
2.2 Knowledge of Family Planning Methods	12
2.3 Traditional methods	14
2.4 Perceived Benefits of Family Planning	15
2.5 Knowledge and understanding of Maternal and Child Health	17
2.6 Key Findings and Recommendations	18
Chapter Three: Community perceptions and attitudes towards male involvement in family planning and reproductive health	21
3.1 Positive Perceptions	21
3.2 Negative Perceptions	22
3.3 Addressing Concerns on Low Male Involvement in FP/RH	26
3.4 Key Findings and Recommendations	27
Chapter Four: Sources of information on family planning and maternal and newborn healthcare	29
4.1 Sources of Information and Commodities for Family Planning	29
4.2 Preferred Sources of information	30
4.3 Challenges men face in Accessing Family Planning Services	33
4.4 Suggestions on How to address the Challenges	33
4.5 Sources of Information and Messages on Maternal and Newborn Health Care	34
4.6 Key Findings and Recommendations	37

Chapter Five: Role of men in Family planning and Reproductive Health	39
5.1 Is Family Planning a concern to men?	39
5.2 Existence of Family Planning Champions	41
5.3 Spousal Communication and decision making	45
5.4 Preferred Role for Men	45
5.5 Community Recommendations for Enhancing the Role of Men in FP/RH	46
5.6 Spousal communication	46
5.7 Key Findings and Recommendations	47
Chapter Six: Barriers to male involvement in family planning (FP) and maternal newborn child health (MCH)	49
6.1 Individual Barriers	49
6.2 Cultural and Religious barriers	51
6.3 Health Service Barriers	52
6.4 Policy and Programme Barriers	53
6.5 Ways of addressing Barriers to Male Involvement	54
6.6 Summary of Key Findings	56
6.7 Recommendations for enhancing male involvement in FP/RH	57
Chapter Seven: Policy and Programmatic issues	59
7.1 Existing Family Planning and Reproductive Health Policies	59
7.2 Perspective of Male Involvement in FP/RH	60
7.3 Integration of Male Involvement in the County Plans	60
7.4 Policy Environment	60
7.5 Existence of Policies/guidelines at Facility level	61
7.6 Implementation of Policy documents	62
7.7 Impact of policies	62
7.8 Information Management	62
7.9 Challenges	64
7.10 Opportunities	64
7.11 Proposed Recommendations by Respondents	65
7.12 Key Findings and Recommendations	67
Chapter Eight: Narrations for male involvement in family and reproductive health	69
References	76
Survey Personnel	77
List of Tables	
Table 1.1: Distribution of counties by cluster	3
Table 1.2: Distribution of Interviews per cluster	4
Table 4.1: Challenges men face in accessing FP services and their proposed solutions	34
Table 4.2: Preferred Sources of Information for Men and Reasons for Preference	36



1



2



3



4



5



6



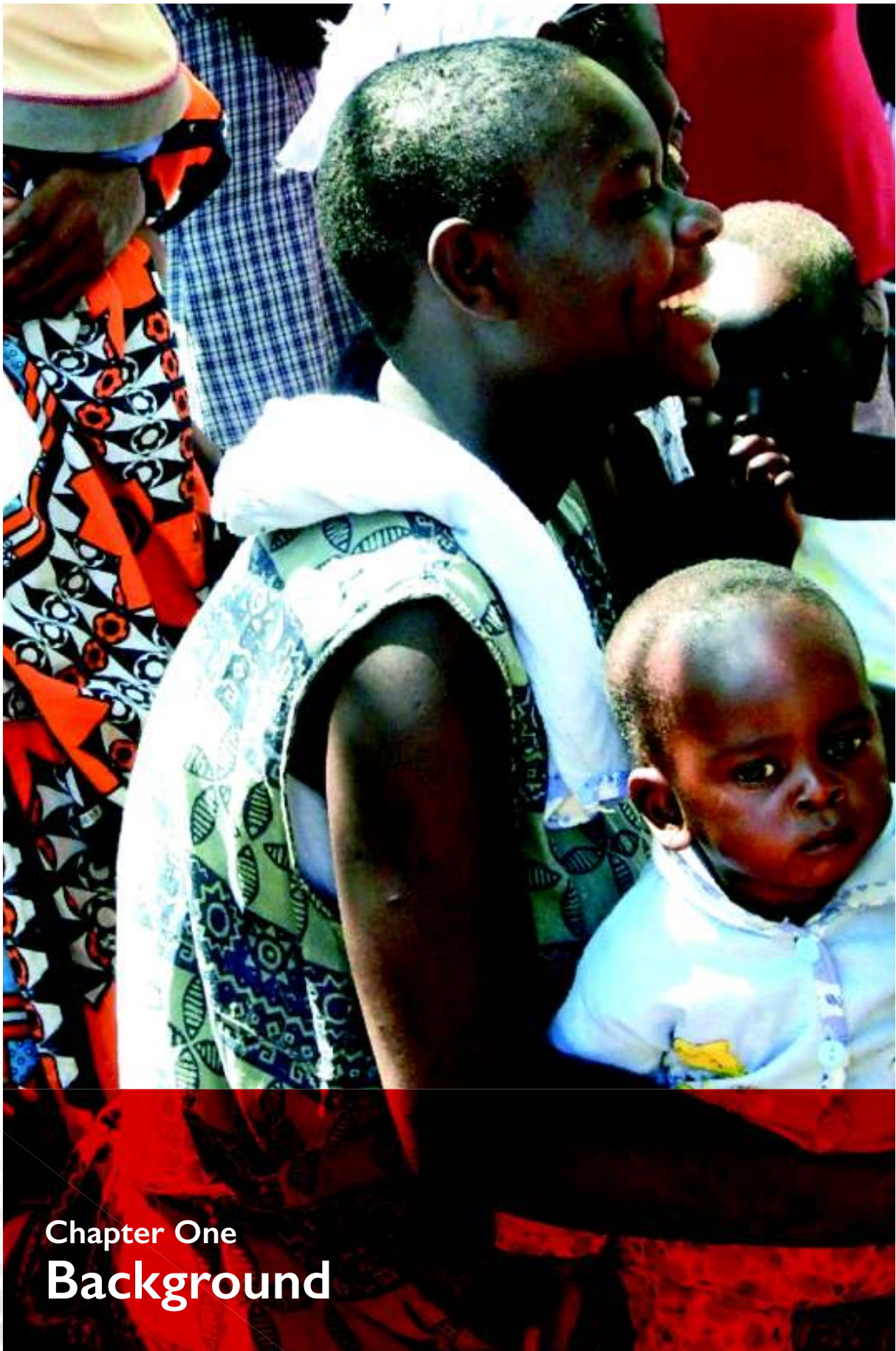
7



8

Abbreviations

AIDS	Acquired Immune Deficiency Virus
ARHDP	Adolescent Reproductive Health and Development Policy
CDH	County Director of Health
CHEW	Community Health Extension Worker
CHW	Community Health Worker
DHMT	District Health Management Team
FBO	Faith Based Organization
FGD	Focus Group Discussion
FP	Family Planning
FPAK	Family Planning Association of Kenya
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IDI	In-Depth Interview
KDHS	Kenya Demographic and Health Survey
KII	Key Informant Interview
KSPA	Kenya Service Provision Assessment
KNBS	Kenya National Bureau of Statistics
MI	Men Involvement
MCH	Maternal and Child Health
MOH	Ministry of Health
NASSEP	National Sample Survey and Evaluation Programme
NCPD	National Council for Population and Development
NGO	Non-Governmental Organization
PoA	Plan of Action
PMTCT	Prevention of Maternal to Child Transmission
RH	Reproductive Health
STI	Sexual Transmitted Infections
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
WHO	World Health Organization



Chapter One Background

Chapter One: Background

In the 1960s, motivated by desire to lower the rate of natural population increase and improve the health of mothers and children, Kenya became the first nation in Sub-Saharan Africa to formally adopt a national family planning programme. Interestingly, more than 10 years after its adoption, Kenya reported eight births per woman, one of the highest fertility levels in the world, resulting in an annual population growth rate of about four percent.

After a decade of experience with a family planning programme, fertility began to decline. A few years later the family planning programme improved and enjoyed support at the highest political levels in the Kenya Government and among the international donor community. By the year 2009, the fertility levels had fallen to five births per woman. The decline in fertility levels over the years was coupled with an increase in the use of contraception among married women.

To sustain the observed decline in fertility, the Government has continued to create an enabling environment for implementation of Family Planning (FP) and Reproductive Health (RH) programmes. For example, the Government with support from partners and stakeholders has put more emphasis on the use of family planning, antenatal care (ANC), delivery, and postnatal care (PNC) services in a bid to improve the health and wellbeing of the population. This emphasis has been backed by the provision of resources for improving access to these services. According to the 2008-09 Kenya Demographic and Health Survey (KDHS), less than half of the married women in Kenya use a family planning method to limit their fertility. At the same time, over 90 percent of pregnant women in the country make use of ANC services at least once, and less than half of them make the recommended four (4) ANC visits for each pregnancy. Less than half of the pregnant women give birth with the help of a qualified health service provider thereby hampering efforts to reduce maternal and child deaths. The uptake of postnatal service is equally poor. This points to the need for the Government to continue strengthening the FP and RH programmes for

better results. One of the identified key challenges facing these programmes is the relatively low level of male involvement in FP and RH. This is despite the fact that the policy framework (*Reproductive Health Policy and Population Policy for National Development*) in Kenya provides for greater involvement of men in FP and RH programmes. For Kenya to effectively promote male involvement in FP and RH, there is need to understand and address the contextual issues behind the low male involvement.

At the 1994 International Conference on Population and Development (ICPD) held in Cairo, the concept of Male Involvement (MI) was described as follows in the Plan of Action (PoA) that resulted from this conference:

“Responsible sexual and reproductive behaviour among men which includes men supporting women’s use of family planning, maternal and child health care services. This also entails prevention of sexually transmitted infections (STI) and using male methods to enhance family planning”.

The promotion of male involvement in FP and RH will foster better relationship between men and women as equal partners in promoting the wellbeing of their families as well as help to achieve equity in gender relations and responsible sexual behaviour. In Kenya, programme efforts to promote male participation in FP and RH have been minimal.



A few projects, such as the Male as Partners Project and Young Men as Equal Partners Project that were implemented by Family Planning Association of Kenya (FPAK), were in response to the 1994 ICPD PoA to enhance male involvement. For the purpose of this survey on Male Involvement in Kenya, the operational definition of male involvement revolved around men supporting women's use of family planning, maternal and child health care services.

1.1 Objectives of the Survey

The overall objective of the Male Involvement survey was to collect information that would contribute to the understanding of factors that influence the involvement of men in family planning and reproductive health in Kenya. Specifically the survey sought to:

- a. Assess community members' knowledge on family planning and reproductive health.
- b. Assess community members' attitude and beliefs towards family planning and reproductive health.
- c. Assess the extent to which men are involved in family planning and reproductive health.
- d. Identify barriers to men's involvement in family planning and reproductive health.
- e. Establish the existing policy and programme responses to male involvement in family planning and reproductive health.
- f. Generate pragmatic recommendations for enhancing men's involvement in family planning and reproductive health.

1.2 Survey Organization

The Male Involvement survey was undertaken by the National Council for Population and Development (NCPD) in collaboration with the Kenya National Bureau of Statistics (KNBS) and Ministry of Health (MoH). A National Steering

Committee and a Technical Committee were set up by NCPD to provide guidance and oversight in the implementation of the survey. The National Steering Committee was made up of the following organizations:

- a. National Council for Population and Development.
- b. Kenya National Bureau of Statistics.
- c. Ministry of Health.
- d. Ministry of Devolution and Planning.
- e. Population Studies and Research Institute.
- f. Family Health International.
- g. Population Council.
- h. Family Health Options of Kenya.

The Technical Committee consisted of technical staff appointed from the organizations that made up the Steering Committee.

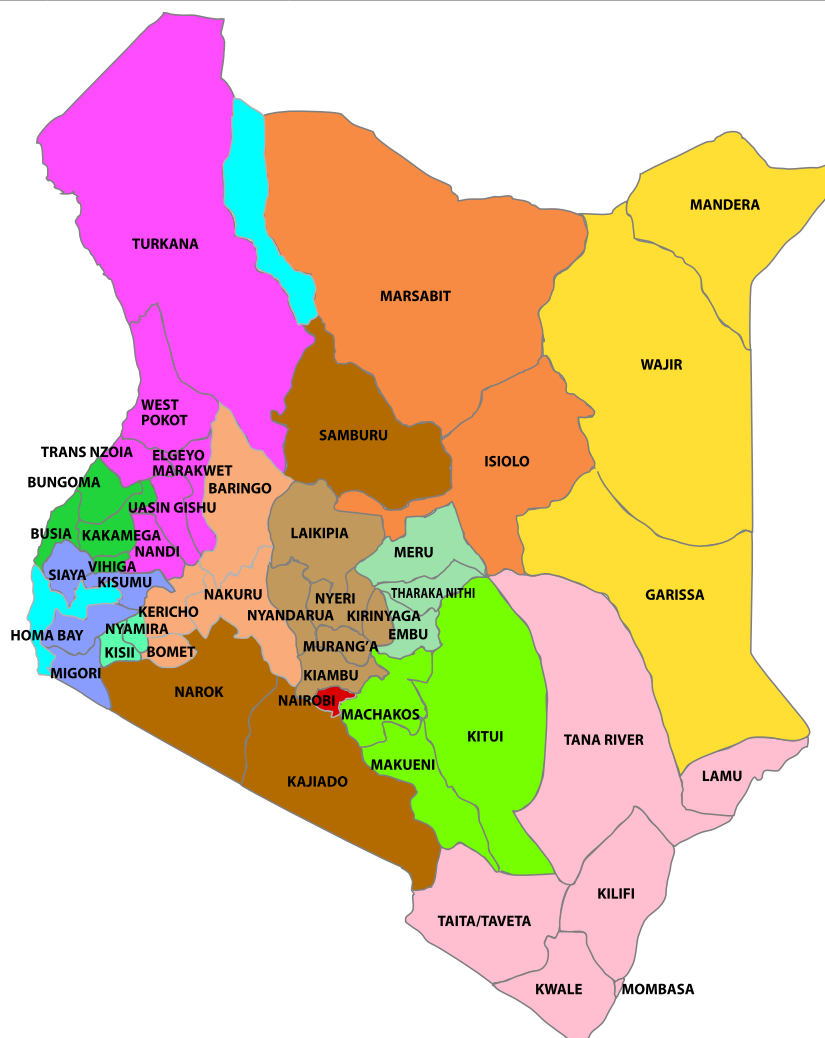
There were 13 teams that were constituted to collect data from various clusters of the country. Each team, comprising of a supervisor, moderator, note taker, and a driver was assigned to one cluster. Before commencing field work, each team developed a work plan for conducting Focus Group Discussions (FGDs), In-depth Interviews (IDIs), and Key Informant Interviews (KIIs). Based on the work plan, the team supervisor mobilized communities and made all the necessary appointments with survey respondents after which the moderator and note taker followed up with data collection. Funding of the survey was provided by the Government of Kenya.

1.3 Sample Design

This was a national survey that covered all the 47 counties in Kenya. These counties were grouped into 13 clusters based on socio-economic and socio-cultural factors, religion, ethnicity and proximity to each other. Table 1.1 shows the distribution of counties by cluster.

Table 1.1: Distribution of counties by cluster

	Cluster	Counties
1	Nairobi	Nairobi
2	North Eastern	Garrisa, Wajir, Mandera
3	Upper Eastern	Isiolo, Marsabit
4	North Rift	UasinGishu, ElgeyoMarakwet, West Pokot, Turkana, Trans Nzoia, Nandi
5	South Rift	Kajiado, Narok, Samburu
6	Lower Eastern	Kitui, Makueni, Machakos
7	Western	Kakamega, Vihiga, Bungoma, Busia
8	Nyanza South	Kisii, Nyamira, Migori (Kuria)
9	Nyanza North	Kisumu, Siaya, Homa Bay, Migori (Luo)
10	Central	Kiambu, Murang'a, Kirinyaga, Nyeri, Nyandarua, Laikipia
11	Central Rift	Nakuru, Kericho, Bomet, Baringo
12	Coast Regions	Mombasa, Kilifi, Kwale, Tana River, TaitaTaveta, Lamu
13	Central Eastern	Meru, Embu, Tharaka Nithi



*Kenya Map with the survey clustered counties

In each of the clusters, the teams were to conduct a minimum of 6 FGDs, 6 KII, 2 IDIs, 10 exits and one observation in all the visited facilities. Selection of the areas where the interviews were done was guided by the NASSEP IV clusters selected for the 2014 Kenya Demographic and Health Survey (KDHS). The purpose of using the KDHS clusters was to relate the qualitative findings of the Male Involvement survey with the quantitative findings of the 2014 KDHS. In selecting the areas for the Male Involvement survey data collection, the common and unique characteristics of the counties in the cluster were used to ensure fair coverage. The areas selected for the survey were therefore nationally representative.

1.4 Survey population

In each of the Male Involvement survey clusters, FGDs were conducted with married males aged 15-24 years, married males aged 25-54 years, married females aged 15-24 years and married females 25-49 years. Additionally, FGDs were also conducted with a mix of married men and women aged 15-24 years, and a mix of men and women aged 25-54. Separate focus group discussions were conducted with Persons with disability. The purpose of using all

these groups was to get a complete picture of the issues around male involvement in family planning and reproductive health.

Key informants were identified in each of the MI clusters from among national policy makers, County Directors of Health, County leaders, community leaders, and FP and RH champions at community level. In addition to this, In-depth interviews (IDIs) were conducted with service providers of selected health facilities in the MI clusters. At each of these health facilities, one (1) observation and ten (10) exit interviews with male clients who had come for FP/RH services or those who had accompanied their spouses to the health facility to receive these services were conducted. Where cases of unique individual experiences of male involvement in FP/RH were encountered, these were documented as narratives with a maximum of two (2) per MI cluster. At the National level, two (2) KIIs were conducted with policy makers from Ministry of Health and the National Council for Population and Development. These two organizations were purposively selected because of their key role in population and health policy and programmes implementation in Kenya. Table 1.2 gives a summary of the interviews that were conducted in each MI cluster.

Table 1.2: Distribution of Interviews per cluster

No.	Regions	FGDs	Community Leader	Policy Makers National and County	Facility In Charge (IDI)	Exit Interview	Observations	Narratives
1	Nairobi	13	6	5*	4	10	4	2
2	Central	11	6	6	3	10	3	2
3	Central Eastern	11	6	3	3	10	3	1
4	Upper Eastern	11	6	1	2	10	2	1
5	Lower Eastern	11	6	3	3	10	2	2
6	Central Rift	13	6	3	2	10	2	2
7	South Rift	11	6	3	3	10	3	1
8	North Rift	11	6	6	3	10	2	2
9	Nyanza North	8	6	4	2	10	2	1
10	Nyanza South	7	6	2	2	10	2	2
11	Western	11	6	3	3	10	1	1
12	North Eastern	6	6	1	2	10	2	1
13	Coast	11	6	4	3	10	3	2
	Total	135	78	44	35	130	31	20

*There were County directors of health who were not interviewed because of other commitments. Two Policy makers were interviewed in Nairobi



The overall objective of the Male Involvement survey was to collect information that would contribute to the understanding of factors that influence the involvement of men in family planning and reproductive health in Kenya

I.5 Data Collection Tools

A total of seven (7) qualitative data collection tools were developed for the MI survey. These tools were designed to capture information on reproductive health, family planning and maternal and child health. Below are the data collection tools:

- i. Focus Group Discussions Guide.
- ii. In-depth Interview Guide.
- iii. Key informant Interview Guide.
- iv. Exit Interview Guide.
- v. Observation checklist.
- vi. Narrative guide.
- vii. Document review: Policies, strategies and guidelines.

The English version of the data collection tools were developed in a workshop by the Technical Committee. These tools were then pre-tested before being shared by the Steering Committee for approval and finalization. The English version of the FGD guide was then translated into Kiswahili, Mijikenda, Somali, Borana, Kamba, Meru, Embu, Kikuyu, Kalenjin, Kisii, Luhya, and Luo languages. The translation of these guides were done to enhance communication during the FGDs. Following is a brief description of the purpose of each of the seven (tools):

i. Focus Group Discussions Guide

This tool was designed to capture information on community knowledge and understanding, sources of information and services, perceptions and attitudes, access to services, role of men, and spousal communication in relation to FP and Maternal and Newborn Care.

ii. In-depth Interview Guide

This tool looked at the availability of FP and RH services, facilitating factors for male involvement at facility level, data capture and reporting system, opportunities and challenges, and recommendations for improvement of FP and RH services.

iii. Key Informant Interview Guide

The focus of this tool was on the knowledge, sources of information and services, access and availability, male involvement, couple seeking behaviour, role of leaders, facilitating factors for male involvement, barriers to male involvement, and recommendations for improving male involvement in FP and RH.

iv. Exit Interview Guide

This tool was designed to solicit information on the services and information offered to the respondent at the health facility, experience of the client, and recommendations for improving male involvement in FP/RH services.

v. Observation Checklist

What was observed while visiting selected health facilities. The things to be observed were opening time of the FP/MCH service area, availability of service charter, Information and Education materials on FP/RH, and friendliness of FP/RH service area to men.

vi. Narrative Guide

This tool was designed to solicit information, document personal experiences with family planning and reproductive health with special focus on male FP champions. The tool also collected data from respondents who were identified to cover their story of having either too many or few children and how their spouses have supported them.

vii. Document review

Policies, strategies and guidelines

1.6 Recruitment and Training

For the purpose of collecting data for the MI survey, a total of twenty five (25) research assistants were recruited through a competitive process. This process commenced with an advertisement in

the national newspapers inviting qualified social scientists and those with related fields aged above 30 years to apply for the available positions. Those who applied and were shortlisted were invited for interview with a panel comprising staff from NCPD, KNBS, and MoH. From the twenty five

(25) successful candidates, ten (10) were initially selected to attend a pre-test training for a period of ten (10) days during which the survey tools were pre-tested. This was followed by a ten (10) days main training for the survey field work where all the twenty five (25) research assistants were trained on interviewing and note taking skills using the five (5) survey tools. During the main training the research assistants were paired and assigned clusters for field work.

I.7 Field Work

The MI survey field work commenced on 20th March and ended on 15th May 2014. A vehicle was allocated to each of the thirteen (13) teams for use during the entire period of field work. Each team conducted interviews and recorded them using notebooks and digital voice recorders in accordance to the work plan developed during the main training. The notebooks and recorders complimented each other. The teams met every evening to discuss the day's experiences, expand on the field notes they had taken during the FGDs, KIs, and IDIs, discuss any questions that did not elicit adequate responses during the interviews and provide suggestions on how best to deal with the same questions in upcoming interviews. This informed the planning for the activities of the coming days. Team reports were sent to the NCPD headquarters on a weekly basis for data processing. Whenever necessary, consultations were held between the Technical Committee and the teams to help clarify specific issues arising from conducted interviews.

The Technical Committee and the field supervisors ensured that the data quality was up to par. All the completed interviews were handed over to the field supervisors who checked them thoroughly before sending them to NCPD headquarters where Technical Committee members would counter-check the data quality by reading the transcripts and listening to the voice recordings of the interviews. Additionally, Technical Committee

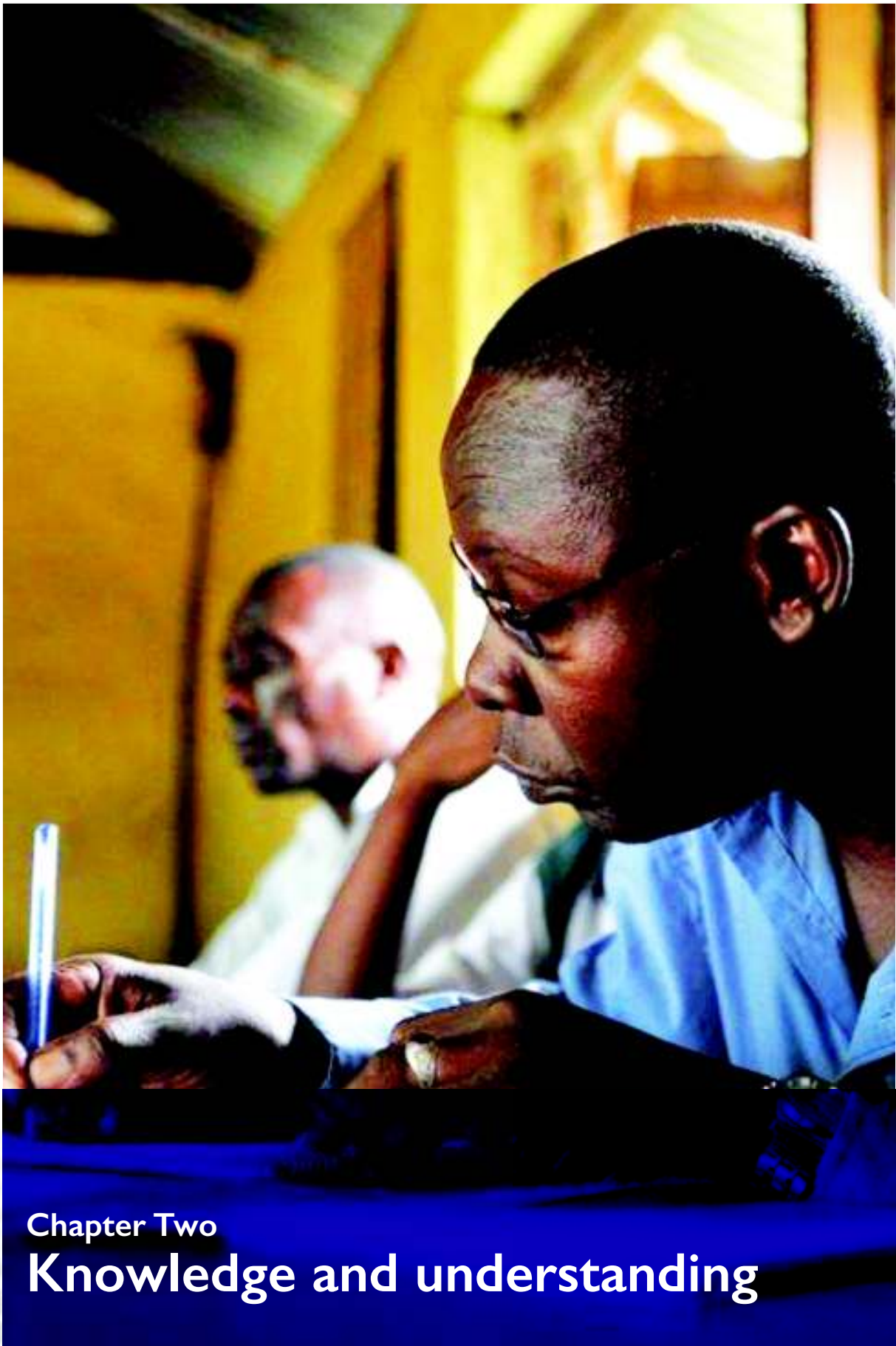
members made spot checks in the field where they accompanied the teams to various interviews and provided guidance and advice where necessary.

I.8 Data Processing and Analysis

NVIVO (V10) software was used to process the qualitative data of the MI survey. The software assisted to access, manage, shape and analyze textual data. Ten (10) of the research assistants who participated in the field work and whose scripts from the field interviews were considered to be excellent were selected and trained for the data processing.

The following steps were undertaken in analyzing the survey data:

- A codebook was developed for each qualitative data (FGDs, KIs, IDIs) after reading through the scripts from each category of the tools and cluster. This gave a list of key emerging themes that responded to the survey objectives.
- The codebook was entered into the NVIVO (V10) software. It was expanded with more themes by reading through all the scripts imported into the software.
- Conceptual and substantive categories were generated from which codes were developed. All common themes were coded and categorized in a standard way using the "tree nodes" structure so that comparisons could be made across sub-samples for ease of analysis.
- Summaries were made in tabular form per thematic area.
- Verbatim "quotes" were used to support key issues and messages.
- Content analysis was done including information about what is most or least common, unique, popular. Comparisons were then made across group types and cluster regions.
- Report writing.



Chapter Two Knowledge and understanding

Chapter Two: Knowledge and understanding of family planning and maternal and child health



In Kenya, knowledge of family planning is nearly universal, with 95 percent of all women aged 15 to 49 years and 97 percent of men aged 15 to 54 knowing at least one modern method of family planning.

Among all women, the most widely known methods of family planning are male condoms, injectables and pills, with about 89 percent of all women saying that they know these methods. Around 6 in 10 women have heard of female sterilization, the IUD, implants, and the female condom. With regard to traditional methods, about two-thirds of women have heard of the rhythm method, and just under half know about withdrawal, while folk methods are the least likely to be mentioned. There has been little change in levels of knowledge of contraceptive methods among all women since 2003. The level of knowledge of female and male sterilization and of the IUD has declined since 2003, while knowledge of implants and withdrawal has increased slightly.

Maternal health remains a challenge in Kenya. Although skilled attendance at delivery has been demonstrated to be the highest impact intervention with postnatal care, obstetric care and family planning for reducing maternal deaths in Kenya, most women (42%) have little choice but to give birth at home because of lack of transport and long distances to health facilities. The problem is particularly common in hard to reach areas where health facilities are poorly equipped and are far from homes, with no passable road or transport available.

This chapter focuses on: community understanding and knowledge of family planning, community knowledge of family planning methods, perceived benefits of family planning and community perception of maternal and newborn health. Relevant quotes from various discussions provide evidence for each of the thematic areas and

categories identified. This section concludes with lessons learnt and suggested recommendations.

2.1 Understanding and Knowledge of Family Planning

Under this section the survey sought to establish respondents' understanding of reproductive health and family planning. However, the responses indicate participants' understanding of family planning/child spacing rather than the broad area of reproductive health. Subsequently, in the focus group discussions the moderators tended to go straight for family planning rather than probe for reproductive health. For this reason the information presented in this section is restricted to family planning.

From all the regions the most popular understanding of family planning (FP) was having the number of children one is able to educate, feed and clothe, essentially the provision of basic needs to the family. The more common understanding of FP was child spacing, the gap between the births of children, and examples were given of 3-5 years spacing or 4-5 years spacing; making reference to the health of the couple as well as the unborn child. Some of the statements that support this include:

'Good health for both men and women is very important for their reproductive age in order to give birth to healthy children'—It's very important to have a Family that one can manage'.

Adult Men, FGD – Kisumu County, Nyanza North

In the South Rift, FP is understood generally as child spacing and the number of children one can manage to raise. However, from one of the focus group discussions with women, they indicated that they have no knowledge of FP and have therefore not practiced it. This is the group that stated that giving birth was up to the point they could not get pregnant any more. For them family planning was a new concept.

‘Giving birth to children after a specific period is important to us but there is nothing like Family planning in our community’.

Female Leader – Narok County, South Rift Region

‘FP is not good —it is ungodly— we old men hate Family planning because when children are born that is what we want. Which is better, a big home or a small home? We don’t like Family planning at all because it is like we are being oppressed by that person who has a big Family. The Maasai says— Naainhookienkang’sapuknaar —enkang’kiti (‘God give me a big Family that rules a small one’)

Adult Men, FGD – Kajiado County, South Rift

In Nairobi, Upper Eastern and Central Rift regions FP was likewise commonly perceived as having the number of children that one can feed, educate and clothe. In addition it was also considered as a way of preventing unwanted pregnancies. The following quotes from different regions have a lot in common; being very explicit about the size of the Family that one should have and the importance of being able to provide for the Family materially.

‘I have used Family planning, I have had children at the time I want or even get children who I can be able to provide for, not to have children all the time without a plan, if I get a child this year, I must wait like two or three years before getting another so that this one can go to class one or two so that I can get another one so as to get time to educate them’.

Adult Women, FGD – Nairobi County

‘According to what I know FP is a way to give birth to the number of children that you can educate, you can bring up, you can afford to cloth them and also giving them good provision of nutritious foods. So you can’t give birth to children that you cannot afford to bring up, educate or even feed. Even treating them becomes a problem, so it depend with the person and whether he is capable of bringing them up’.

Adult Men, FGD – Isiolo County, Upper Eastern Region

‘It is one way of getting the number of children one can feed and educate while giving the mother time to regain good health, and both mother and father get time to work. You may be having many children one in form 1, one in form 2, the other in nursery, and others in university and class 8, so you realize the parent will be confused. Too many children may make life very difficult’.

Adult Men, FGD – Nakuru County, Central Rift Region

‘Helps one to bring up children well, provide them with a good education, good health to both the mother and the child by getting them nutritious food while being energetic, since if a woman gives birth every year, she could become unhealthy’.

Young Women – Nakuru County, Central Rift

In the Western region FP was perceived as a method of preventing the spread of HIV/AIDS as expressed by a young male participant:

'I think Family Planning is a very good thing. First, it protects you from venereal diseases like HIV, Gonorrhoea and other diseases'.

Young Men, FGD – Vihiga County, Western Region

A slightly different perspective was presented for South Nyanza and Central Rift regions where the understanding of FP was within the context of having children according to the amount of land owned. These are regions where land is expansive and forms the basis for the economy and therefore children as a labour force constitute a key factor of production and sustenance as well as security.

In another instance the perception of family planning assumed a political undertone where it was felt that the need for numbers was paramount in order to gain political mileage particularly being able to qualify for a constituency. This argument is based on past experience, for example the Ilchamus in Central Rift were convinced that they have lost out politically for the sheer fact that they do not have the numbers. A high population was associated with domination of other population groups. For this reason they attributed their marginalization to their sparse population. Thus while they acknowledged that Family planning may be good for other population groups and regions, it was at the same time not perceived as ideal for them. These sentiments are well illustrated in the FGD in Central Rift Marigat area:

'Family planning is generally good— but not for Ilchamus people. We are one of the Maa communities and the Samburu people have sidelined us. We are isolated and we are very few. We wanted a constituency of our own but our population is still small so we want to get more children so that we get the constituency'.

Young Men, FGD with Ilchamus – Marigat, Central Rift

'Many children in a Family are a source of wealth and power and are a sign of Family continuity'.

Young Men, FGD – Bomet County, Central Rift Region

In Upper Eastern, apart from the general understanding of FP as child spacing, respondents thought of FP as a way of controlling the population for economic stability. This group incorporated a development perspective, most likely because of their relatively young age and educational levels. This also demonstrates possible exposure to information that links population to development. Similar findings are evident in other regions. For instance in Nairobi, married youth were able to relate Family planning with population and development. The views from various regions are summarized below:

'I have heard that Family planning is very vital for Kenya today. We need to maintain and manage our families to keep the population growth rate manageable so that the resources we have can be well utilized'.

Young Men, FGD, Merti – Isiolo County, Upper Eastern Region

'Family planning can help create more jobs. If there are few jobs and a few job opportunities, everybody is likely to get something. It will also reduce poverty and crime rates since people have the number of children they can adequately take care of'.

Young Men, FGD – Tharaka Nithi County, Central Eastern Region

‘What I can add is that Family Planning is very important to the whole nation especially now as regards to education. Right now the country has many problems. Many are learned but there are no jobs. If we have a moderate population that the government can take care of, then everyone will have a chance of getting employed’.

Young Women, FGD – Cheptais, Bungoma County, Western Region

‘The country will benefit. Big populations will negatively affect the environment and the country will not be able to feed its people’.

Young Men, FGD – Mombasa County, Coast Region

‘First it gives the government an easy time, meaning that when people have so many children and may be the government has limited resources, they will not be able to manage the population that is there’.

Young Men, FGD – Homa Bay County, Nyanza Region

‘Family planning has great advantage to the country since the country will be able to plan for schools and hospitals. If the population is high, the government is not able to meet the demand for drugs in hospitals leading to much misery among the people. But with family planning, the country will be financially stable, the people will be healthy and able to work and produce and this will be good’.

Adult Women, FGD – Nairobi County

The findings also show that some young people from across the regions have better understanding of the relationship between Family planning on one hand and population and development while some did not have. Hence, there is urgent need to target the youth with relevant information and services for behaviour change.

2.2 Knowledge of Family Planning Methods

This section presents the respondents knowledge of various Family planning methods. The findings indicate that knowledge on Family planning is widespread. Majority of the respondents were able to identify the various methods of Family planning both traditional and modern. The range of methods mentioned include; condoms, pills, injections, implants/Norplant, coil, tubal-ligation, prolonged breastfeeding, withdrawal, and rhythm. The findings revealed that injectables and pills are widely used.

Emergency contraceptive pills were particularly mentioned by the younger category of men and women. The withdrawal method was reported to be least used as it was said to require much discipline that most couples found to be a challenge. Prolonged breastfeeding was mentioned in 5 clusters only: Coast, Western, Nyanza South, Nairobi and Nyanza North. On probing for other methods, reference was made to vasectomy but was not an overly popular method. In some regions it was shunned and equated to castration.

The survey established that condoms are widely used for protection against STIs. The condoms were said to be commonly used because they are readily available, cheap, and sometimes given free. The following excerpts illustrate the findings:

‘These diseases (HIV/AIDS) are the ones that made condoms to be popular’.

Adult Men, FGD – Maua, Meru County

‘Condoms—These are commonly used because they are readily available, cheap and sometimes are given freely’.

Young Men, FGD – Embu County, Central Eastern

‘Condoms are the most used method because people fear going to the hospitals to do vasectomy’.

Adult Men, FGD– Kapkorio, Nandi County

The findings further indicate that condoms are mostly used as an alternative to long term methods such as vasectomy.

Evidence shows that use of condoms is not common among married couples. Respondents stated that most couples would not use the condom in marriage because of concerns around trust. Furthermore, the use of condoms is associated with unfaithfulness among partners. Other respondents felt that condoms could be laced with substances that could be harmful to the body.

‘Some people fear using the condom in marriage because they say it has oils that are not safe to the body. They also feel that they trust each other hence no need to use condom’.

**Young Men, FGD – Tharaka Nithi County
Central Eastern**

‘We can use condoms, but if your wife finds you with them she will say that you were using them with another person. Our wives don’t understand that condoms are methods that can be used for FP in the house’.

Adult Men, FGD– Nyamira County, Nyanza Region

‘As women, we will fight our husbands if they come home with condoms. These men here in Malongo do not use condom. As a wife if you get condoms in your husband’s pocket, you either throw them away or burn them in the fire’.

**Adult Women, FGD – Homa Bay,
Nyanza North Region**

‘Being married, they do not use condoms and those who do, use them for promiscuity. Personally there is no way I will tell my husband to use a condom with me, he will want to know why. Ironically, if I get pregnant he will say the child is mine and that I gave birth when he was not ready. As a woman, you will end up being let down and if you are a business lady you will have to stop all your other activities. It’s us women who suffer, always taking pills every day and injections every three months’

Adult Women, FGD – Nairobi County

‘To add to what he has said, when you use condoms your wife says that you do not trust her. You then go ahead and make love and try to use withdrawal method instead of condoms and you find it does not work completely’.

Young Men, FGD – Nairobi County

‘She will reason that if you can use a condom with her, you can also use it with someone else. This leads to mistrust. Men use condoms with those they don’t intend to have long relationships with’.

Young Men, FGD – Kwale County, Coast Region

In rural and hard to reach regions the traditional methods of child spacing were more commonly mentioned than in the urban settings. The most popular traditional method as listed by participants in Nyanza North, Nairobi, Nyanza South, Coast and Western regions was prolonged breastfeeding. In the Coast Region, for example, breast feeding was perceived as a permanent method of contraception for women:

I only know the permanent method for women. However, the Quran instructs that women should properly breastfeed their babies for two years and five times a day for two years. Even if the husband demands sex like “Kisiji” (some tiny bird that is prolific in mating), the woman will not fall pregnant. The challenge has been to fully breastfeed due to lack of time and that is the major reason we are unable to plan our families. If we took breastfeeding seriously, we would not need pills, injections or anything’.

Adult Men, FGD – Lamu County, Coast Region

2.3 Traditional methods

Traditional methods that were mentioned include:

- i. Living in separate huts—*abila*— from the Nyanza North Region.
- ii. Pronouncement by a mother in law— (“those children are enough”) in Vihiga, Kakamega, Bungoma and Kalenjin.
- iii. In Nyanza South, sitting on an anti-hill “Ekegeegegetebu” that no longer produces ants. Following the principle of association it was believed that a woman who sits on the non productive anti-hill would not get pregnant.
- iv. The use of herbs is also a popular method and was described in Nyanza North, Nairobi, South Nyanza, Central and Coast. It was explained

that traditionally concoctions are mixed and ingested by women for family planning. Use of herbs was said to be common at the Coast region and was reported to be used by those women who do not want any more children.

Some of the groups stated as follows:

I have heard of some herbs. There is also another plant called “nyono” whose leaves look like those of a pawpaw tree. I hear its seeds can be used but if a woman takes more than 21 seeds she will never give birth’.

Young Men, FGD— Tiwi, Kwale County

Women can also use traditional herbs as a permanent method but it is only used by women who are not planning to get more children’.

Adult Women, FGD – Bilisa, Tana River County

The men used to have a separate hut called “abila” where the man could be sleeping during the period the wife is breastfeeding until a certain age then the man can come back and sleep in the same hut as the wife’.

Young Men, FGD – Kagwa, Nyanza Region

Aaru’’: Staying away from your wife. It was used in the past where you stay away from your wife’

Adult Men, FGD R7 – Meru County, Central Eastern

I am the one who uses the natural method. I go to the forest and collect roots which when I take, my wife cannot get pregnant’.

Young Men, FGD – Cheptais, Bungoma County, Western Region

‘That is just a medicine, a traditional medicine that women tie on their waistline and when they sleep with their husbands, they don’t fall pregnant’.

Young Men, FGD – Isiolo County, Upper Eastern Region

‘The mother gets an opportunity to regain her health after delivery because she loses a lot of blood during delivery. If the mother takes time between pregnancies, she regains her body/health meaning that she can even be productive in the community and earn a living’.

Young Men, FGD – Kagwa, Rambira, Homa Bay County

2.4 Perceived Benefits of Family Planning

This section presents the findings on the perceived benefits of family planning. There is consensus that family planning has numerous benefits to the individual, family, community, and the nation. For instance, at the individual level, family planning is reported to improve and maintain mother’s health. It was further observed that if the health of the mother is safeguarded, this would enable her to engage in economic activities that would contribute to the welfare of the family. The following excerpts demonstrate the participants’ perceived benefits of family planning:

Besides being beneficial to the mother, family planning improves the health of children and the entire family, as illustrated in the subsequent quotes:

‘Family planning helps the child in that the child gets enough love from the mother. When you get another child when the other one is still very young your attention shifts to the new born thus the first child doesn’t get enough love’.

Adult Women, FGD – Rorok, Elgeyo Marakwet County North Rift

‘It will assist in safeguarding the health of the mother because accelerated child bearing will bring risks to the mother and of course if the number of children is more than what the couple can take care of, it will strain the mother psychologically and even physically and she will end up with a not very good situation’.

Person with Disability, FGD – Runyenjes, Embu County

‘The father will be stress free in terms of provision of school fees and he will be able to take care of that child in good health. On the side of the mother, she will be having good health and she will have enough time to recover after delivery. The baby (child) will have time to breastfeed well because they will have good spacing with the other child. To the community, the school will have fewer children so they will be able to read and get educated well’.

Adult Men – Maua, Meru County

‘Family planning is good for the mother so that she also she has the time to go out and work. When you space the children, they will be healthy and sleep well. Even the neighbours will see that you have a happy Family’.

Adult Women – Bilisa, Tana River County

‘Will have proper care – caring for the child during sickness, ensuring proper clothing and nutrition’.

Young Women, FGD – Kilifi County, Coast

'Family planning helps the woman regain her health if they are able to use it for about two years. The mother also gets an opportunity to breastfeed the baby, unlike situations where the woman has a pregnancy and has a young baby at the same time. She will not be able to breast feed the young baby.'

Adult Men, FGD – Taita Taveta County, Coast Region

'It help the child to get things that she/he can get like good education, good food, good clothing and such like things.'

Adult Men, FGD – Siaya County, Nyanza North Region

'For the child, if he/she is breast fed throughout the recommended period, their immune system is boosted and they grow very healthy.'

Adult Men, FGD – Isiolo County, Upper Eastern

Family planning was cited as playing a key role in reduction of poverty. The respondents argued that the fewer the number of people the easier it is for the government to provide basic services such as education and health. Some summed up responses on the benefits of FP include:

'As a result of family planning the government will have a population that is manageable. If people don't plan their families the population will be unmanageable especially in terms of security and other social amenities'

Adult Women, FGD – Rorok, North Rift

'It helps the government to adequately support the people- because if the population is more than the wealth can support, that becomes a challenge but if the population is planned, that is very good indeed'

Young Men, FGD – Thika County, Central Region

'The community will be safe since there will be no idlers. When you have many children that you are unable to educate, some of them might become thieves or some may run away because of the problems at home.'

Adult Men, FGD – Meru County, Central Eastern Region

'The nation will be able to plan for the population in terms of health and education facilities.'

Adult Men, FGD – Nakuru County, Central Rift Region

'The country will benefit. A large population will negatively affect the environment and the country will not be able to feed its people.'

Young Women, FGD – Mombasa County, Coast Region

In a few instances, reference was made to social support as well as improved relationship between couples with women having adequate time to attend to their spouses. It was generally observed that FP reduces stress for the father and mother enabling them to better attend to the needs of the Family.

2.5 Knowledge and understanding of Maternal and Child Health

Although this survey was largely focused on family planning; but because of the close relationship between family planning and maternal health, specific questions on the understanding and perception of maternal health were also asked. It was also of interest to establish men's understanding of maternal health, in particular the role that they play during their partner's pregnancy, delivery, post partum and child care.

In almost all the regions maternal health was described within the context of vulnerability and the need for adequate rest for a pregnant woman. It was stated as a time for reduced physical activity and the need for good nutrition as well as access to health care. However, as an exception, a pregnant woman among the Maasai was expected to eat little; taking *Nkarrar*—a mixture of milk and water that is just enough to sustain her while keeping the baby small. This is understandably so drawing from their experience where they have lost mothers at home during childbirth due to obstructed labour; especially when the babies are too big and in the absence of health facilities in close proximity for skilled birth attendance.

Pregnancy was considered a time when men play their role more fully as household providers. During focus group discussions with men it was reported that men pay keen attention to expectant mothers. However, it emerged from the discussions with men that ordinarily men would not accompany their partners to the clinic for ANC and delivery, this being perceived as a woman's responsibility. The men stated that they were concerned and would invariably provide transport. Maternal and newborn health was related to nutrition in terms of a balanced diet for the mother, clinic attendance for both the mother and new born for immunization as well as psychosocial support. The importance of maternal health was identified as: disease prevention both for the mother and the baby, good health for the mother and baby and breastfeeding of the baby.

In Nairobi young fathers had more current information regarding maternal health including exclusive breastfeeding for six months, psychosocial support/attention, hygiene, exercise and the importance of prevention of maternal to child transmission (PMTCT). In addition paternity leave was valued as enabling a father assist a mother after delivery. The benefits of attending clinic and delivering under skilled care were clear to the respondents. Some of the benefits mentioned include, knowing the health status of the child and monitoring its growth, knowing the health status of the mother, vaccination/immunisation status of the child, reducing unnecessary costs related to complications in delivery and reducing the maternal and child morbidity and mortality.

'The advantage of delivering with the help of a skilled birth attendant is that it can enable the mother to give birth to a healthy baby. If the baby is healthy it gives the husband easy time to care for the baby together with the mother'.

Adult Men, FGD – Siaya County

'On the issue of home delivery, birth complications in such a scenario may result in a women developing fistula. It is a shameful thing, and if a man is unable (read pay) to have corrective surgery for the fistula, he may end up ditching such a woman leading to the breakdown of the Family. I would rather sell a cow and take her to hospital for delivery to avoid such'.

Adult Men, FGD – Nyandarua County, Central Region

‘Going to the hospital helps the mother to know the do’s and don’ts; she is able to take precautions. It gives the mother knowledge of how to bring up the baby in a good way. The antenatal clinics are also good for monitoring the baby’s and the mother’s development which ensures their wellbeing’.

Person with disability, FGD – Embu County, Central Eastern Region

‘The mother and the child get all the vaccines and immunizations as well as other checkups’.

Adult Men, FGD – Mogotio, Central Rift

‘First you must look at her environment because she can easily get infected with malaria when pregnant since her immunity is very low. She should sleep under a treated net and the baby should have a balanced diet to remain healthy’.

Young Men, FGD – Young Cheptais, Bungoma County, Western Region

‘Clinics and immunization will protect the child from getting infections, illnesses and disease’.

Young Men, FGD – Isiolo County, Upper Eastern Region

2.6 Key Findings and Recommendations

Summary of Findings

This chapter highlights the respondents’ understanding of family planning, knowledge of available methods as well as the perceived benefits

of family planning. It is evident from the findings that most of the respondents have a good understanding of Family planning. They stated that family planning involves the spacing, delaying as well as limiting of children.

Regarding knowledge on available family planning methods, respondents identified a wide range of methods both traditional and modern. It was however established that the traditional methods were more widely mentioned in the rural and hard to reach areas compared to urban settings.

The findings further show that the condom is not a popular method of family planning. Some respondents felt that a condom can be used to spread diseases. They stated that it can be laced with infectious substances to cause disease. However, other respondents stated that some men use condoms as an alternative to the long term methods such as vasectomy, which was equated to castration, hence unacceptable.

As regards perceived benefits, family planning was widely recognized as beneficial to the child, the mother, family, community and the country at large. Some of the benefits associated with family planning include; safeguarding the health of the mother and the child, economic wellbeing of family, community and the country. It was indicated that Family planning would result in a manageable population and enhance the provision of basic services such as education, health and security. Furthermore, child spacing and limiting of children would promote the participation of women in employment outside the home.

In some communities, however, family planning assumed a political dimension. Some communities felt that family planning would result into further political marginalization on account of numbers. Among these communities family planning was, however, only supported for other regions that were perceived to have huge populations.

I. Key findings

a. Understanding of family planning

Most respondents have a good understanding of family planning and stated that family planning involves the spacing, delaying as well as limiting of children.

b. Knowledge of family planning methods

Respondents mentioned a wide range of methods both traditional and modern. Traditional methods were more widely mentioned in the rural and hard to reach areas compared to urban settings.

c. Condom Use and Vasectomy

The few FP methods available for men; condom and vasectomy are not popular methods of family planning because their spouses are opposed to their use.

d. Benefits of family planning

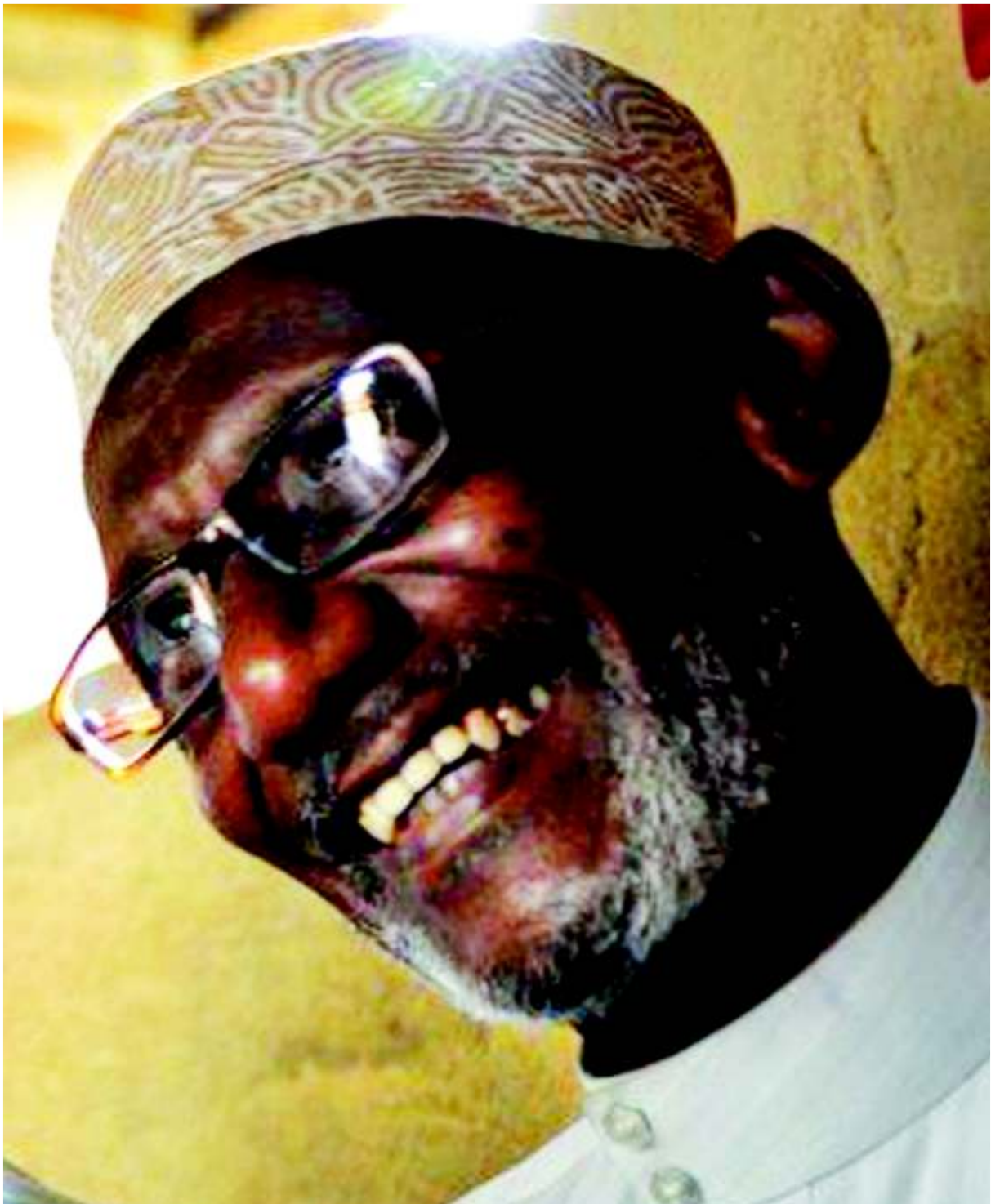
Perceived benefits of family planning include; safeguarding the health of the mother and the child, economic wellbeing of family, community and the country a large.

e. Family Planning and population size

Some communities were opposed to family planning because they reckoned that its use decreased the population size. Low population size was seen as a reason for political marginalization.

2. Recommendations

- a. There is need for continuous education to address the prevailing misconceptions about condom and vasectomy. Couples who have undergone vasectomy should be identified and used during sensitization and advocacy campaigns to dispel myths about vasectomy.
- b. The traditional methods of family planning were more widely mentioned in the rural and hard to reach areas compared to urban settings. This indicates a knowledge gap between the traditional and modern methods of family planning that should be addressed.
- c. Some communities believe that family planning would result into further political marginalization on account of numbers. There is there need for innovative approaches to address the needs for different communities to appreciate family planning as a development issue.



Chapter Three Community perceptions

Chapter Three: Community perceptions and attitudes towards male involvement in family planning and reproductive health

This chapter explores the way members of the community perceive men’s participation in family planning and reproductive health, and the issues surrounding their involvement. Findings from the survey show mixed responses that reflect both negative and positive views.

Generally, the findings show a more negative perception of male involvement in FP and RH than the proponents of male participation.

In most of the clusters respondents had negative perception on male involvement in FP/ RH stemming from their experience with use of certain methods of FP, cultural norms and religious beliefs, myths and misconceptions.

Those with positive views on male involvement in FP/RH demonstrated a better understanding of the health and economic benefits that accrue from use of family planning among couples. This presents an opportunity to build on this support.

3.1 Positive Perceptions

3.1.1 Positive Views on Male Involvement

Findings reveal that there is an increased awareness by men on the challenges of large family size which prompts them to be concerned and involved in FP issues. Majority aired their views that land is not expanding and they do not have enough resources to meet the needs of many children. Positive views on male participation in FP were also expressed particularly by young men and women who demonstrated a better understanding of some of the health and economic benefits of FP for the child, mother and family. This was more evident in urban regions. Respondents in an FGD in Western reported:

‘My wife and I started family planning so that when we go to the farm, the baby can bring us water, at times we can leave her at home doing other jobs and even prepare tea. It should not be one baby after another. Who will feed the other?’
 Young Men, FGD – Bungoma County, Western

The same sentiments were shared by a participant in Vihiga who asserted that:

‘Again, our farms are very small. So, if you decide to give birth to so many children, like five sons and you have one acre of land, when they grow up where will they build their houses and also where will you plant food crops to feed them?’.
 Young Men, FGD – Vihiga County, Western

‘What I can add is that Family planning is very important many people are educated but with no jobs. If we have a moderate population that the government can take care of, then everyone will have a chance of getting employed?’.
 Young Men, FGD – Nairobi County

Similar positive views in support of male involvement in FP/ RH were expressed by heterogeneous FGD respondents in Kitui and Nyeri Counties. The men supported the idea that practicing FP prevents poverty and reduces some of the challenges associated with large family sizes. It would enable couples to have the desired number of children they can

take care of. For these reasons most of these men are motivated to give financial support to their partners to access FP services.

Some regions like Nairobi and parts of Nyanza and Central Rift reported the presence of donor funded FP/RH projects that promote male involvement in FP/RH through the approach of using male FP champions. The projects are making strides in reaching out to men through their own peers who are trained to be change agents. These FP champions pass correct information to demystify myths and misconceptions about FP and the men are engaged as equal partners in the practice of FP/RH. But the prevailing gender norms in these communities are still an impediment to male involvement.

Although the data shows that some faith is opposed to use of modern contraception particularly permanent methods, they are supportive of birth spacing of two-three years for health benefits to mother and child. Their teachings also support the idea of male participation especially during pregnancy and after child birth. They said that the Islam religion advocates for men to assist their spouses during times of need which could include participation in Maternal and Child Health care. A young man argues that:

‘The Islamic faith advocates for men to assist their wives during times of need’.

Young Men, FGD – Wajir County, North Eastern

The above findings presents opportunities to pass information and create awareness in the communities on the correct and effective use of family planning methods; through innovative communication approaches that meets the needs of these communities.

3.2 Negative Perceptions

3.2.1 Health Related Concerns, Myths and Misconceptions

In the focus group discussions participants were asked to describe their perception and attitude towards male involvement in family planning and reproductive health. The participants raised various views around male participation in FP/RH across the regions. Health related concerns and myths and misconceptions were cited as the most common reasons for avoiding the use and practice of family planning. Majority of the male respondents perceived the use of FP methods as a threat to practicing FP because it poses serious risk to the health of their partners. There is a common belief by men in almost all regions particularly the rural settings that use of certain FP methods causes infertility, weight gain and low libido among women. This influences both women and men attitude towards FP/RH and hampers male participation.

‘We hear FP brings about infertility and makes women barren and it is also said it can bring infections’.

Young Men, FGD – Wajir County

‘I am a businessman in the local market where I hear women speak about side effects of FP. I have heard FP interferes with their menstrual periods, causes excessive bleeding for long and brings infertility. Women have to go to hospital to be given medicine to normalize their periods. So men spend a lot of money to treat them. I have myself done that; I have taken my wife to too many hospitals’.

Adult Men, FGD – Machakos County

One of the respondents in the FGD in Nyanza North had this to say:

‘What I hear and know is that FP spoils the bodies of our women. That there are some methods which when a woman uses makes her grow fat. You may just be surprised that your wife is using FP when she has grown fat. Is this true or not?.....’

Adult Men – Kisumu County, Nyanza North

‘There are those who use the pills and they are not able to receive their menstrual periods which leads to dryness to a woman. This dryness reduces pleasure and the woman is not interested and may also lead to a yeast infection’.

Adult Women, FGD – Nyamira County

‘The tablets cause swelling on the legs, which is very painful’.

Young Women, FGD – Isiolo County

Majority of the females young and adult respondents in different regions also reported that low male participation in FP/RH is a result of their partners opposition to the use of contraception because of the misconceptions about FP.

‘They are opposed to FP methods because they believe it makes the women cold and they feel uncomfortable during sexual intercourse. Others think it makes women to be promiscuous and as such they are reluctant to be supportive of FP’.

Adult Women, FGD – Kajiado County, South Rift

‘They say it reduces fertility, if you get injected it can make you not to get another child. What if you have only one child and it dies?’

Adult Women, FGD – Uasin Gishu County

On the other hand male youth respondents in certain regions particularly Nairobi, Central Eastern, Western, North and South Nyanza were of the opinion that family planning should be practiced after giving birth to the desired number of children because according to them the practice of FP means stopping to give birth. One of the male respondents in Kisii had the following to say:

‘The young men say that they want to have many children first then do FP later. They wonder, suppose they get only two children and the two die, what will happen next? Such scenarios trap people into getting many children before they think of planning’.

Adult Men, FGD – Kisii County, Nyanza South

Similarly, some women also raised health concerns on the side effects of FP methods:

‘The injections are not good because they lead to a lot of bleeding and you avoid going to crowded places.’

Adult Women, FGD – Kitui County

3.2.2 The Role of Tradition and Culture

Socio-cultural norms in most Kenyan communities dictate the behaviour that is permissible for women and men. This includes beliefs related to family planning and maternal and child health care. For example, norms related to women being passive and men being assertive or aggressive can lead to low level of male participation in FP/MCH care. These gender norms affect spousal communication. The ability to discuss FP/MCH with one’s spouse

or partner is very important for the approval of FP and consequently male participation and practice in FP/MCH care. A woman who has not discussed FP with her partner is not only less likely to use contraception but she may also assume that her partner is opposed when he may not be.

The gender roles as stipulated in culture support the notion that care of young children and family planning, including contraception, is the sole responsibility of women. Majority of respondents in the rural regions reported that some men do not want to participate in FP, maternal and child health care because they fear that some people may say they have lost power and their position as the head of the family. Male participation in FP/MCH care is therefore seen as being indicative of male disempowerment:

'In most cultures, family planning has been a woman thing, we do not talk about it, a man will wait for the woman to take the lead in family planning'.

Adult Men, FGD – West Pokot County, North Rift

'People say the 'man has been sat on' by the wife if he involves himself too much with Family issues at home'.

Adult Women, FGD – Kericho County, Central Rift

'Men do not assist women when they are pregnant because they say the woman has sat on the man. That now he is like a woman because he is carrying out women responsibilities. That is why they can't even take the children to hospital when they are sick; this also depends on the community where the woman is married'.

Adult Men, FGD – Migori County, Nyanza North

Men's involvement in maternal and newborn care is also hampered by cultural expectations and

taboos. This was reported in Maasai and Kalenjin communities. Men are not allowed to hold a new born baby or even stay near a new born baby. As stated by the following respondents:

'To hold a new born baby! No! No! We cannot until the baby is big enough. Even when you are seen around a new born baby, you are asked to go away it is a taboo'.

Adult Men, FGD – Kajiado County, South Rift

Findings from certain parts of Coast and Central regions also show that majority of the respondents, both men and women view FP practice as a woman's responsibility and it is therefore up to her to ensure that she does not get pregnant. A better understanding of this perception was illustrated by one respondent from Coast region:

'It's really hard for a man to get involved in such matters of FP because it is not important for him, it's for women. It is important for the woman because she is the one to make sure she doesn't get pregnant. But it is not important for the man'.

Young Women, FGD – Mombasa County, Coast

A young FGD respondent in Laikipia also responded:

'Men's view is that women in marriage should go for Family planning while men should look for money'.

Young Men, FGD – Laikipia County, Central region

The prevailing societal norm in some communities such as the Samburu, Maasai and Mijikenda is that children are a source of wealth and continuation of life. The desire for more children impedes men involvement in FP because the practice is seen as reducing wealth and the continuation of the family tree as stated by these respondents:

Amongst the Maasai, a big Family is a sign of prestige, because if pointed out that the home has such a number of wives and such as number of children, one feels good?.

Young Men, FGD – Narok County, South Rift

When they see people visiting clinics, they start pointing fingers at them that they are unable to feed their children that is why they are practicing FP?.

Young Men, FGD – Nakuru County, Central Rift

Sex preference is another factor in these communities that also plays a significant role in hindering active male involvement in FP/RH. For example in West Pokot where male sex preference is high, the practice of FP is low until a desired sex and number of the children is achieved. In an FGD a woman respondent noted that:

We have a problem of culture, a couple may have children up to eight girls and the man still insists that they must have boys. He does not care how his children are going to be taken care of as long as he has boys?.

Adult Women, FGD – Pokot County, North Rift

I went to see a midwife while contemplating a permanent method of FP, She advised me against it because I didn't have a boy child'.....

Community Leader – Taita Taveta, Coast Region

Findings from key informant interviews conducted with County Directors of Health across all the regions support the above findings that male involvement in FP/RH is generally very low. They also noted that the low level of male participation is as a result of cultural and gender norms, myths

and misconceptions. They reported that very few men accompany their partners for FP/RH services because most communities view these roles as women's and not the responsibility for men.

My opinion is that the male are not so much involved in FP. First of all, I think they don't have enough knowledge concerning FP and reproductive health issues which they consider to be women issues. I don't have actual statistics how males are involved in Family planning but it's important for them to be involved in reproductive health issues?.

County Health Professional – Uasin Gishu County

Family planning in this county is a woman's affair, There are very few men who are involved and even they are involved just as a matter of allowing women to go to the clinic?.

County Health Professional – Kwale County

3.2.3 The Role of Superstition

Data from the survey show that men's participation in some parts of Nyanza, Western, Central Eastern and South Rift is also influenced by superstition. They do not want to get involved because they feel they should give birth to as many children as possible so that when some are bewitched and die, they do not remain childless. Men in this area are in fear that their children are likely to die due to the perceived existence of witchcraft in their area. These witchcraft tend to discourage men from active participation in FP.

A male respondent in an FGD had this to say:

‘I have a different opinion. Others say that they would have planned but now there is tradition and witchcraft. If they get two children and do vasectomy, what will they do if the two children die afterwards? Therefore, they say that they get many children first so that they do not find that they had miscalculated. This complicates the problem.’

Adult Men, FGD – Kisii County, Nyanza South

3.2.4 Religious Beliefs

Findings from the survey show that religion has a lot of influence on FP practice resulting to low participation of men.

Data from the respondents across the clusters particularly Nairobi, some parts of Eastern, Coastal, North Eastern and North Nyanza where Islam and Christian religions dominate have a common view on low male participation in FP. Responses from both men and women oppose the use of permanent methods of FP. Data from the FGDs show that those practicing FP are accused of going against the religious teachings on morality and life. The respondents who associated FP with morality had this to say.

‘Others say, once you use modern methods of FP you are not Muslim or you have sinned’.

Young Men, FGD – Wajir County, North Eastern

‘It is against religion as they say that the bible instructs people should give birth and fill the earth and they take it literally’.

Young Men, FGD – Nakuru County, Central Rift Region

‘A Muslim man is not involved in FP. Our religion allows a man to have sex with his wife anytime. There is no FP according to our faith’.

Adult Men, FGD – Lamu County, Coast Region

3.3 Addressing Concerns on Low Male Involvement in FP/RH

Generally, there is clear evidence that negative perceptions towards male involvement in Kenya is stemming from religious beliefs, cultural norms, myths and male misconceptions surrounding FP/RH. Various suggestions emerged from the FGD and in-depth data on how to address these concerns.

- **Education and sensitization of men on FP/RH:** lack of information on the various FP methods is a great contributor to the negative perception on male involvement. This underscores the importance of involving men in understanding the health, social and economic benefits of FP.
- **Addressing Myths and misconceptions:** Addressing health concerns and fears about side effects and counteracting the myths and misconceptions that men and women have been exposed to, are essential strategies for improving use and practice of FP.
- **Targeted FP communication on Male Involvement in FP/RH:** by using innovative approaches such as caravans, media talk shows, seminars by professionals in the area of FP/RH will greatly inform the men on the value and importance of male involvement in FP/RH.
- **NCPD to widely disseminate and share with religious and community leaders a multimedia presentation; “Faith and Families for a Healthier Kenya”;** that portrays why FP is consistent with religious values. The presentation was developed by NCPD, inter-Religious Council of Kenya and PRB’s Informing Decision makers to Act (IDEA) project. The presentation stimulates discussions and promotes dialogue among religious communities and is a tool that can promote male involvement in FP.

3.4 Key Findings and Recommendations

I. Key findings

There are both positive and negative perceptions towards male involvement in FP/RH:

i. Positive perception of male involvement in FP/RH

- A good understanding of health and socio-economic benefits of FP by men in certain regions encourages male participation in FP/RH issues.
- Increased awareness by men on the challenges of large family size (poverty, limited land/resources) promotes the need to be involved.
- Practice of birth spacing by religious communities is acceptable and supported by men.
- Use of men as change agents in FP/RH is a successful approach that promotes male involvement.

ii. Community Negative perception of male involvement in FP/RH

Stemming from experience with use of certain FP methods, myths and misconceptions, cultural norms, and religious beliefs.

● Health concerns, Myths and Misconception about FP

- Use of FP causes excessive bleeding, infertility, weight gain, low libido in women. This influences negative attitude among men that hampers male participation.

● Influence of Culture

- Cultural and gender norms support the notion that the care of young children and use of contraception, is the sole responsibility of women and men are not involved.

● Influence of religion

- Islam and Christian faith opposes the use of permanent FP methods which is against their religious teachings. This restricts men to support and practice FP.

2. Recommendations

- Educate and sensitize men on importance of FP/RH to address their health concerns and demystify myths and misconceptions about FP.
- Use of Innovative FP communication approaches targeting men involvement in FP/RH; case of “Faith and Families for a Healthier Kenya”; a multimedia presentation that portrays why FP is consistent with religious values.
- Policy solutions need to embrace gender equity as a defining principle; to ensure that policy guidelines and programmes apply to all people, and implemented in such a way that men are constructively engaged as equal partners in FP/RH.



Chapter Four

Sources of information

Chapter Four: Sources of information on family planning and maternal and newborn healthcare



Knowledge on FP and RH on the part of both men and women is vital for the provision and uptake of FP and RH services. The 2008-09 KDHS found that over 90 percent of both men and women aged 15-54 years and prospectively had knowledge on Family planning methods.

In assessing the level of community members' knowledge on FP and RH, the Male Involvement survey sought to establish the various sources through which communities in general, and men in particular, accessed information on FP and RH. The survey also sought to find out which information sources are preferred by men. These findings will help policy makers and programme managers to assess the most effective channels of reaching men, and communities in general, with FP and RH messages and services. This chapter presents the findings on the sources of information from the interviews conducted with community members.

4.1 Sources of Information and Commodities for Family Planning

This section provides detailed information on sources of Family planning information, how commodities are acquired, access to family planning services, the challenges faced and suggestions for improvement. The information obtained by the 2014 Male Involvement survey addressed the following issues:

- From where do men get information and commodities on FP?
- What is the most preferred source of FP information and commodities for men?
- Which FP methods are commonly used by men and couples?
- Which FP methods are less commonly used by men and couples?
- Which FP methods are never used by men?

From the findings the sources for Family planning information and commodities are varied. Generally, participants in the discussions stated that information on FP was obtained mainly from health facilities followed by radio and television. During the interviews, women respondents aged 25-49 reported that they got information on FP from health facilities, radio, Chiefs barazas, churches, seminars as well as through outreaches conducted by the CHEWS and CHWs while doing door to door FP campaigns. On the other hand young women aged 15- 24 reported to have received information from their parents, magazines, teachers, elder siblings, and peers who have previously used FP methods.

When the same questions were subjected to both young and older men, they equally reported that they got the information on family planning from radio, Chiefs barazas, health facilities, friends, their wives or girlfriends, and churches. It was evident that men preferred getting this information from experienced male friends and CHEWs.



The discussions with men revealed that commodities, in particular condoms can be easily obtained from shops, social joints, chemists and health facilities. When it came to vasectomy, pills, injections and implants they reported that they can only be obtained from the health facilities. However, they noted that health facilities were less frequented due to stigma as FP is associated with women. For this reason preference was placed on male FP providers at the community level. Below are quotes from participants that illustrate this:

'Yes we tell each other but we trust the Male CHEWS and CHWs more. Most men do not trust their wives because they think they don't want to become pregnant. They also cannot go to the health facilities because it is full of women and harsh nurses. You see, women talk and soon the whole village will know you went for Family planning and this is really demeaning. If we could have more male CHEWS who will teach men-- many men will take Family planning seriously.'

Adult Men, FGD – Makueni County, Lower Eastern

Television and radio advertisements were also mentioned as a source of information. However the information was said to be scanty and mainly focused on creating public awareness but additional information, tests and procedures had to be obtained from the health facilities.

'We get it also from Radio, TV, Newspapers and Friends but the information given is not enough, so you have to go to a clinic to get it from a qualified person.'

Adult Women, FGD – Marsabit County, Upper Eastern

4.2 Preferred Sources of information

On the preferred sources of information, both men aged 15-24 and 25-54 said they preferred getting the information from their experienced male friends and CHEWS as the health facilities are not men friendly. They pointed out that labels such as Maternal Child Health Clinics were suggestive of a programme and services geared towards women and children. In addition, they cited poor reception from the gate keepers and health service providers as barriers to information access. They also reported preference of obtaining the information from their wives as they are the end users of the commodities. Newspapers were also preferred by men.

'Through CHEWs because they walk from door to door and usually will find you with your wife such that you can't even dodge them. They speak candidly about Family planning and since you are in your house you will be free to ask anything without anyone hurrying you up.'

Adult Men FGD R8 – Elgeyo Marakwet County, North Rift

'Friends and wives are important too. If you have an honest wife she will take you through all the products and information helping you understand better than the health providers who are always in a hurry to clear the queue. But if you have never used any method it is good to go to the health facility and be guided and have yourself tested.'

Adult Men R8 – Uasin Gishu County North Rift

4.2.1 FP Methods commonly used by Men and Couples



Nationally, injectables were found to be used mostly by couples aged 25–54. Participants reported that this was convenient as they only visited the health facilities once in three months thus saving them time and money. Some women said injectables were more convenient especially where husbands do not approve the use of Family planning methods as it was more secretive compared to the daily pills, implants and coil. Young men and women aged 15–24 mostly used daily pills and emergency pills.

Although condom is a method of Family planning, most men and women said they did not use it as a method of Family planning but as a means of preventing STDS (Sexually Transmitted Disease) and HIV/AIDS. Regionally North Eastern, South Rift, parts of North Rift and Coast were against the use of condoms as they all reported to have increased promiscuity within the community. North Eastern and Coast reported that condoms were not allowed in both the Muslim and Catholic religions thus they have to follow the Bible and Quran teachings on the use of Natural methods like Standard Days Method, Abstinence and Withdrawal.

‘Condoms prevent pregnancy and STIs. Most of us use it with our mistresses and girlfriends. However, as a couple we prefer injections or pills’.

Adult Men, FGD – Homa Bay County, Nyanza North

When it comes to Standard Days Method and withdrawal the respondents said couples using it have to be very careful. A man has to understand the safe and unsafe periods of a woman so that they can use a condom or withdrawal method. The two must also be in their right state of mind and not under the influence of drugs or alcohol.

‘Few use the natural methods like counting days and withdrawal. A drunkard or a drug addict cannot use the natural methods’.

Adult Men, FGD – Siaya County, Nyanza North

4.2.2 FP Methods less commonly or never used by Men and Couples

Most of the respondents said that the less commonly used FP methods by couples are condoms, pills, IUCDs, and withdrawal. It was reported that most of the women will not allow their spouse to use a condom. In all the regions, the men and women, both young and old, were in agreement that vasectomy is the least popular FP method. Few men were willing to go through the minor operation while their women thought that men who undergo vasectomy may not have an erection any more or worse still may become impotent. In some communities abstinence was ruled out completely as it was believed to cause cancer. This is evident in the following quotes:

‘Sleeping separate from your wife (abstinence) is very difficult amongst the Luo community as a means of Family planning because it will cause cancer. Secondly when it comes to condoms some women do not agree to the use; they think you despise them and you do not love them as your spouse. That is the reason why those two methods are not commonly used amongst spouses in this community’.

Adult Men, FGD – Kisumu County, Nyanza North

‘Another one is vasectomy. I particularly would like to undergo the process but the stigma in this community is so high that no woman will look at me the same way. My wife even threatened to divorce me if I underwent the procedure, so unless I pretend I am travelling then go to another town to undergo the operation and come back when healed. But my worry is these women are nowadays educated and she will realize that I have undergone the procedure’.

Adult Men, FGD – Nyamira County, Nyanza South

‘I have two wives and they keep on competing in giving birth. I once told them since they are not ready to do any Family planning, I will undergo vasectomy. I almost lost both of them as they went back to my in-laws to report me. Since then, I use condoms with them’.

Adult Men, FGD – Siaya County, Nyanza North

4.2.3 Men’s Access to Family Planning Services

When it came to access to FP services respondents were asked how the available Family planning services meet the needs of men. Most participants in the discussion groups reported that FP methods were available and can easily be accessed. However, men find it difficult to access these services because of the stigma they may face from their peers, wives and service providers. Men reported that condoms were easily accessible but they had to wait until evening when there are no queues at the health facility and then pick them.

‘.... It is not possible for me to get up and go to the hospital. These services should be in the community and not just in the hospital The government should have CHEWS walking with condoms in the community’.

Adult Men, FGD – Vihiga County, Western

Some service providers encourage men to go for family planning by putting measures that enable men to be served conveniently as is shown in the following quote:

‘There are those who accompany their wives for Family planning and they don’t wait on the long queues’

Adult Men, FGD – Bomet County, Central Rift

4.3 Challenges men face in Accessing Family Planning Services

The various challenges that men face in accessing FP services were raised by the respondents. These challenges include; opposition from the spouses because most women don't want their husbands to undergo vasectomy or use condoms, long distances to the health facilities, some service providers were said to demand money yet it is understood that these FP services are free, rude remarks from service providers, and in most health facilities the service hours are short as clients are served from 8.00 am to noon.

'One of the issues is the embarrassment caused by the nurses. They do not realize that you are going to use the condom for family planning or even against STI. They just think that you are having an affair that is why we don't go for them'.

Adult Men, FGD – Nairobi County

4.4 Suggestions on How to address the Challenges

From the discussion groups men generated suggestions as to how the challenges facing their involvement in Family planning can be addressed. This is evident in the following quotes:

R12: Men use condoms and that is a fact. These condoms should be placed in strategic places like toilets, bars and CHEWS homes. The hospital hours should also be increased from 8.00 am to 5.00 pm.

'These women should be sensitized and let them understand that a man who has a condom is not promiscuous but taking precaution. This sensitization can be done in their women chamas and chiefs Barazas'.

Adult Men – Kakamega County, Western



Table 4.1: Challenges men face in accessing FP services and their proposed solutions

Challenges	Proposed ways to solve the challenges
Opposition against use of condoms and vasectomy	Sensitize men and women on the importance of Family planning; this can be done through the chiefs Barazas, workshops and road shows. On the same, women should allow and support their husbands to use condoms and vasectomy.
Long distance to health facilities	Services brought to the community by family planning champions such that in every village there is a CHEW or a Family planning champion who will avail services.
Short service hours in the health facilities	Service provision hours should be extended to the whole day on particular days like Mondays, Wednesdays and Fridays- this will encourage people to visit the facilities any time without fear of waiting for long or being turned down.
Free access to condoms limited by stigma	Allow CHEWS to distribute family planning methods that do not require prescription especially during the chiefs barazas. Condom dispensers should be placed in strategic areas such as bars, supermarkets and tertiary institutions.

4.5 Sources of Information and Messages on Maternal and Newborn Health Care

This section presents findings on the main sources of maternal and newborn healthcare information for communities in general and men in particular. It also discusses the findings on the men preferred sources for this information.

Most communities in Kenya access information on maternal and newborn health care from mainly health facilities, electronic media (especially radio), and friends. Other sources mentioned by the communities include CHWs, public meetings such as chief's barazas, churches, seminars, and posters. In South Rift, North Rift and Western regions. Traditional Birth Attendants (TBAs) were also mentioned as a source of information on maternal and newborn care. The quote below from North Eastern Kenya shows that health facilities are the main source of MCH information for communities:

Mostly hospital, when women are pregnant they will visit the clinics where they are given a booklet that has all the appointments and they have to adhere to it. When she gives birth, the baby is immunized and she's given a return date. She is also advised on when to start using Family planning methods and when to start having sex with the husband. She is checked for many things the most compulsory is HIV/AIDS. If you like they can check for cervical cancer or breast cancer'.

Young Men, FGD – Wajir County, North Eastern

Both men and women interviewed generally indicated that men usually get information on maternal and newborn care from their spouses, electronic media (especially radio), and friends. Seminars, health campaigns in the community,

CHWs, parents, public meetings and reading materials such as pamphlets were also mentioned as other sources of this information. In some of the regions such as Central, Eastern, Coast, and Western, the internet and mobile phones were mentioned. In North Eastern Kenya, another key source of information is the meeting attended by men every evening which is known as *fadikudirir*.

On the sources of information preferred by men in general, radio and spouses featured prominently during the discussions. Other sources which were also mentioned include friends, chief's baraza, posters, and magazines. Though parents, health facilities, VCTs, and churches featured in the community discussions, this was only in a few

instances. For example, church as a preferred source of information was mentioned in Central, Nyanza North, and North Rift.

'Through Radio and TV, when they watch news, even buy newspapers and read, perhaps there is an advertisement on MCH. Some ask their wives because they say they are the one who give their women money to go to clinics and while drinking they discuss these things.'

Young Women, FGD – Meru County, Central Eastern



Health facilities were less frequented by men due to stigma, as Family Planning is mainly associated with women

Some of the reasons given for the preferred sources of information were varied. Table 4.2 shows some of the main reasons given for preference for different sources of information.

Table 4.2: Preferred Sources of Information for Men and Reasons for Preference

Source	Reasons
Spouses	<ul style="list-style-type: none"> • Can tell their husbands what they learnt openly. • They are trustworthy. • Women are more knowledgeable on health issues since they are the ones who mainly go to the clinics. • Men fear going to the hospitals to get information because of stigma and being asked personal questions.
Media (Radio)	<ul style="list-style-type: none"> • Radios are cheap to operate and available in almost all homes. • Clear detailed explanations on health issues are provided. • Information can be passed in vernacular and therefore easily understood. • You can listen to radio when relaxing at home especially in the evenings. • Through radio, you can hear many other interesting messages. • When listening to radio, no one will ask you questions. • You can listen to radio in privacy.
Health Facilities	<ul style="list-style-type: none"> • Professional, experienced, and skilled staff in attendance. • You can trust the information from health workers. • Comprehensive and clear Information. • Information can be provided in private. • You can get other benefits such as bed nets.
Friends	<ul style="list-style-type: none"> • Can discuss freely with friends. • Can ask friends questions of concern.
Churches	<ul style="list-style-type: none"> • Provides guidance on Family life.
Seminars	<ul style="list-style-type: none"> • Issues are discussed in a group. • Issues are discussed exhaustively.

In areas where it was indicated that men do not prefer getting information on MNHC from health facilities, the main reason given for this was the fear men have of being subjected to HIV/AIDS tests which is compulsory during the antenatal period. They also said men are discouraged with the long queues at the health facilities because, in their view, they cannot spend the whole day just to go and learn about MCH. Therefore radio and TV is an easier way for men to get the information as they can listen or watch the advertisements while working or having a drink with their colleagues as they discuss what their wives are taught.

‘Mostly men will never go to hospital because when you are pregnant the nurses insist on HIV/AIDS test which these men are not ready to undergo. Apart from that, there are very long queues at the hospital and men don’t want to waste the whole day there’.

Adult Women, FGD – Nairobi County

‘Yes, they will tell you to go for the test and use your results to know their status not knowing there are married couples who are discordant, their reasoning is so backward, nurses and government should educate these men’.

Adult Women, FGD – Mombasa County, Coast

4.6 Key Findings and Recommendations

1. Key findings

- Due to stigma men hardly go to health facilities for FP information and services.
- The less commonly used FP methods by couples are vasectomy and condoms. This is due to spousal opposition.
- Wives are an important source of FP/RH information for men.
- Mass media and spouses are the most preferred sources of MCH information by men.
- Men decline going to the health facilities with their pregnant wives due to fear of being subjected to HIV tests and long waiting time.

2. Recommendations

- Sensitize men and women on the importance of family planning and maternal and newborn care. This can be done through the media, chiefs Barazas, workshops and road shows. At the same time, women should be sensitized to support their husbands to use condoms and vasectomy for family planning.
- Health services be brought to the community by CHEWs and CHWs. These services should include both FP and RH information and commodities.
- Condom dispensers should be placed in strategic areas such as bars, supermarkets and tertiary institutions where they can easily be accessed.
- Service provision hours should be extended to the whole day on particular days like Monday, Wednesday and Friday. This will encourage people to visit the facilities any time during the day.
- Efforts should be made to improve the friendliness of health facilities to men. This includes posters that incorporate men in the messages, attitude of health workers towards men, and giving men priority in service provision when they come for FP and RH services.
- More sensitization on HIV/AIDS is required for men so as to encourage them to overcome fear and go for couple testing and counselling.



Chapter Five
Role of men

Chapter Five: Role of men in Family planning and Reproductive Health

Although the 2008/9 KDHS findings show that 46 percent of married women are using Family planning, 26 percent of married women or one in four women who report that they want to delay their first birth, space their next pregnancy or not have any more children, are not using any form of contraception.

This unmet need for Family planning has stalled for the last 10 years. This stagnation could be attributed to a combination of various factors. Some of these key factors include: inadequate spousal communication, male involvement, cultural factors, inadequate information or awareness of existing FP/RH service amongst others.

The survey findings show that men have an important role to play in family planning and reproductive health.

‘We do not like family planning because it causes cancer, weight gain and reduces libido in our women’.
Adult Men, FGD – Marakwet County, North Rift

Cultural beliefs and practices such as polygamy and preference for large families are still influential in determining the role men play in FP/RH. Family planning as well as maternal and child health are still considered a woman’s sole responsibility.

‘It is very important because Family planning is a two people affair and should not be one sided but a discussion between a man and a woman in the Family, as Christians and the two as partners’.....
Acting Bishop, Methodist Church – Meru County

5.1 Is Family Planning a concern to men?

There is varied opinion on whether FP/RH is a concern to men. In analyzing the responses from all the clusters, concern or the lack of it was split into two. Among the adult and young male respondents family planning or birth spacing will help reduce the family burden and prevent household poverty. Men are also concerned about taking care of the health of the child and mother to reduce illnesses and associated costs.

‘As elders we teach people. Although we don’t teach them to use condoms, we tell them to be faithful and care about their lives. We also tell the married to take care of their wives, children and themselves’.
A leader from the Luo council of elders

‘Because we fear if our women and children fall ill it is our burden’.
Adult Men, FGD – Meru County, Central Eastern

Fear of side effects, myths and misconceptions is mentioned as one of the common reasons for nonuse of Family planning.

Men in urban regions were more concerned about the high cost of living and gave economic reasons as to why they take family planning seriously. Majority of the respondents indicated that the cultural practice

of naming children after relatives and the perception of children as a source of domestic labour and old age security has contributed to non-use of family planning. However, according to male respondents in Central Rift, family planning is the only way to control their families due to reducing land sizes.

‘Because community land is becoming scarce and cannot be sub-divided amongst the many sons, FP is now becoming a concern’.

Adult Men, FGD – Kericho County, Central Rift Region

The other half of participants stated it was not a concern: Below is a summary of sentiments regarding the lack of concern for family planning and maternal and child health care:

‘FP is a women’s issue because men were not involved from the beginning. It all started as a women’s affair, health workers are more concerned about the health of women and children because it is a woman’s business, hence men take it that way, and even the FP and MCH providers are women. We men shy to ask about such things because it is a woman’s issue’.

Adult Men, FGD – Embu County, Central Eastern

‘It is something for women, there is no consultation and they use without asking their husbands’.

Adult Men, FGD – Isiolo County, Upper Eastern

‘Maternal and child health care is a responsibility of women because men do not have time to go for the services and some do not know its importance. Their responsibility is to fend for the family’.

Young Men, FGD – Vihiga County, Western

In most of the cluster Female FGD participants reported that men have no concern for FP/MCH because of various reasons including habitual drunkenness and irresponsibility, they care less about the health of their wives or children. It was also commonly mentioned in rural regions that FP is not a concern to husbands who work far from their home and are only available once or twice a month.

Although there is general knowledge about family planning, there are a number of participants who believed FP is a method of preventing or stopping child birth. Culture is mentioned in more than half of the regions as one of the factors that cause men not to assume their roles in family planning, and maternal and child health, as mentioned by the following groups:

‘In this community, we believe that one should have many children so that when tragedy strikes you are left with some’.

Heterogeneous, FGD – Elgeyo Marakwet County, North Rift

‘Polygamy is our lifestyle; we marry many wives who compete to have children. It is worse if the children are of the same sex’.

Adult Men, FGD – Marsabit County, Upper Eastern

In most of these regions, FP is also not a concern because of religion,

‘We don’t practice FP because we believe it kills lives’.

Adult Men, FGD – Nairobi County

5.2 Existence of Family Planning Champions

Findings indicate that the respondents could not easily identify family planning champions in their respective communities who speak or encourage other men to use or support family planning. This was mainly attributed to fear of stigma associated with the use of male family planning methods such

as vasectomy. Findings further indicate vasectomy is widely misconceived by men as castration and men who have undergone vasectomy are not respected in the community. However in Nairobi County there are male family planning champions established under the Pathfinder funded project. Excerpts from narratives for two of the champions regarding their views and experiences are presented in the following pages:

Family Planning Champion I (Nairobi County)

Our mission of Male Champions in our community began when as a team of Male Champions began to network with the local administration and also coming up as a team to create awareness of reproductive health to all men within Nairobi County- very populated with a lot of slums and a kind of settlement where because of overpopulation some men are ignorant because of the way they live, the way they were brought up and because of their culture. A lot of fights and war that you hear in marriage is because of that big unplanned family. When the family is big and the man is not able to provide for the family and the family is demanding, the man comes to a point where he has to stand as a man. This results to a fight.

So to minimize that and to bring peace in the family, we thought the best way to counter this is to begin to advocate for small families mostly targeting men because men were left out from the initial beginning of family planning programmes.

Now we began talking to men to understand how to plan their family rather than talking to women. And not only that, we began by having couples meeting. We held a big couples meeting within our community and we began talking to them the challenges they are facing in their family and also we began to share with them the little understanding we have about a good planned family.

Some men are very ignorant, they don't even understand. Some is lack of information, they don't have any information about it although it has been in public domain for so long. You talk about family planning you find they are asking "how can a man do family planning? they don't". We have also been having what we call sensitization activities where we go out sensitizing the community members that this is how it is. We have a banner and we go round within our community just like doing evangelism. You go and talk one on one and ask "have you heard about family planning?" "what is that?" So that is sensitization of the community. So the main issue is lack of awareness of family planning. If they get the concept, everything will be ok. We have also been having some activities that make men to be attracted to the messages: like there was a time we had football matches, volleyball matches and we announced to men, "just come we are having volleyball matches, football matches". Our target is not to do volleyball and football. Our target is to gather together these men and after the games we sit down to see the way forward. This is when we talk about the matters of family planning and distribute condoms. We have seen it working so well.

We are working together with the Ministry of Health through the health centers within our community. Like Kayole we are working with Kayole 1 and Kayole 2 health centers and we have interacted with those people within those health centers such that for referrals we have come up with a programme with them. In Kayole - if a man comes in this health center with his wife or with a baby, bringing the baby to the clinic or the wife to the antenatal care, they are given priority.

Male involvement in family planning, is not easy because of the background, culture, religion, and because of that masculinity of a man. It has not been easy to penetrate in the community with the message of men getting involved in family planning but actually I can say that the message has moved. The message has moved and we can say now you can go find a man or a group of men and you talk to them about family planning and you ask them “ what type of family planning do your wife use?”.

As family planning champions we have actually faced some challenges. It has not been easy going because we begin without knowing but now we have come to understand whatever we are doing is for the community. One challenge we are facing as male champion is lack of proper training. We would like to be trained. We don't have that proper training as male champions and the trainings that we have been having are.. we cant say that it has been enough for us. We need to have the full information because when we talk about family planning we talk about the basics. But now there are questions that other men will never be able to answer because the training that they are given is just to know there are methods of family planning. But when you go deep to ask questions pertaining those methods, they don't know

Sometime you come to them and say “ it is not about you getting the method but it is about you supporting your woman, supporting your wife to have the method and also having the know how of the methods that maybe your wife is using and maybe the side effects of the method and how you can discuss as a family on which method you can use.” So the misconceptions are many and people talk about them openly and sometimes they are challenged if you don't know they are there. Somebody speaks to you something that you have never known is a misconception. If you are a male champion or if you are not properly informed about that, you may say it is true. So that is why we need a lot of forums to educate these men so that they may go with the right message to other people. To reach the youth we have seen is about organizing some activities for them and because now we have an age group of about 20 to 26 years who are married, I mean we can classify them as young couples, we invite them for our couple seminars. We organise for a couples seminar where they come as couples and as we talk about family planning , sexuality, we interact with them and because the topics are interesting and they tend to desire to continue with it the next time you call them they come. We have forum also for single men and women.

Family Planning Champion 2 (Nairobi County)

As a Pastor, that was something which came to me because I normally lead these people and most of the time they are coming to me, “ I need food”, “I need school fees”, “I need this and that”, “ I don’t have food for my children”. So it came to me, what can I do to help this people? In fact even if I will be giving them all food all the way, I am not helping them because this year there is a child, they give birth, next year they give birth to another one...Are we going to help them? I sold the idea to my colleagues, those are other Pastors and they accepted it. So we did it. After launching, we had a couples meeting, party with different pastors. Then we invited APHIAPlus, they came in and we talked about it. And in fact we said in every church we must have about 10 minutes to talk about family planning and we have seen it working because sometimes we change from this Pastor, “you are from this church? , go to that church and you preach and you give that message. So that is how it has been working.

As you can see, you are in Makadara. As we call it Eastlands. Did you know that Eastlands has got the highest population? And in fact we did a statistic, the people who are living in Makadara are too many, they have a lot of children and the house is 10 by 10. Ok. And when you talk about shelter, water, then that is a challenge to them. So it came to me you know these people they must be taught and because most of the people think that to have many children, your name will be great, but now it is not like those years back in 1980’s, isn’t it? Because our forefathers had big shambas, a lot of animals. But today, do we have it? Ha! You cannot give a shamba now for example I do not have a shamba. The shamba I have is only mine. I cannot give it to my son because I do not have a shamba. If I have 2 acres and give it to my son, what I am going to be left with? Nothing.

So that is my passion, you know it is very good if you have kids and you make sure that they have education, they are medically covered, they have shelter and you can afford to feed them without problem. That is what I feel the best and that is because a child is a gift, is a gift from God. You cannot say it is mine. No. It is a gift. If you are given a gift today, do you normally take care of the gift? Very much, isn’t it. Why not our children? And why should you give birth to so many children. You know normally, I have a challenge because many women will tell you “My husband will not listen to that, My husband cannot listen”. What do you mean? You married someone you know, isn’t it? And what agreement was there. So if you tell me “my husband does not want to listen”, you are lying, there is something wrong somewhere. No. Because me I believe one thing, there is no eagle in the family. We are not back in 1990’s or 80’s . You must have family...agree, “we need children. How many?”, “ we need two, one”, isn’t it. But you cannot say “No. My husband is forcing me to have 10 children.” then you don’t have a vision and those are the people we are meeting on the ground especially there are males who cannot understand that we are talking to them about this.

It is a passion for me because I am a...that is why I was involved with family planning for men because the problem is not for women. The problem is with men because before men took this issue of family planning is for women, isn't it? And do you know, it is very rare for a man to know the method his wife is using, "that is not my business. I don't give birth, isn't it?" But initially it is your problem because after the child comes out it has to be your responsibility. You must make sure that he goes to school. The child is now in this world, you must take care of him or her, isn't it? So that is a challenge and it is you to understand this is my responsibility.

So why I thought it is good for me to take this line of family planning for men it is because they think they are getting away from it but instead they are caught up. And they don't understand because you see if my wife, I can give about 10 children, isn't it? But at the end of the day are you going to sleep. All the time "Daddy bring this, daddy bring this", you go mad. So that is how I came to develop that passion and I like it. I liked it because in fact even I have gone to classes to know more about family planning.

Now, most of the time our work is to educate men. We don't now talk with women unless there is something, they need to come with their wives in our meeting. We normally have trainings for them, talks even to the youth, we talk to them about family planning because we saw it was very important to start from the bottom. In fact if you want your son or your daughter to grow well, you must talk to her when she is young to understand and to know what is happening in life. So we have been training, talking to schools, talking to males, having workshops with men. Even here like in this clinic in fact we can tell the nurses we need a workshop with men. So we have been talking to men about family planning, all other things now like gender violence in family planning, normally those are by the way but our area most of the time is how can you do family planning. And we are not forcing men to do it, we want them to support their spouses

In fact we have been given referral books. You come to me looking for a male champion, Oh! male champions are us, our members, we have books. You go visit somebody and you are immediately assisted, we just refer. So when it comes here we normally check every month, how many men have attended the clinic, how was he treated and like now I have a case here where you met me because that man came with the child and the wife and in fact he told me that he stayed on the line for almost one hour. Now that is not good because the MOU we have signed with all clinics in Nairobi, if a man comes with his wife, get him out of the line because men are not patient. Make sure he is attended and he leaves. Let me say our men are not well informed. If they accept they come and understand--- in fact the men we have talked with, we started 30 and we are about almost 3000 men I can take you to those groups. So all what they need, I am telling you, a man is a proud person and when it comes to things like family planning, they are very ignorant.

5.3 Spousal Communication and decision making

Evidence shows that male involvement in Family planning is greatly enhanced by partner communication. Partners, who can decide on the number, spacing and timing of their children are better able to save on resources, increase their household income, invest in their existing children, and better plan their lives.

The survey findings show varied opinion on who makes the decision about use of FP/RH services among couples. Majority of respondents alluded to the view that use of FP/RH services is a woman's decision. This was noted in most of the regions:

‘It is a woman’s decision because the burden of taking care of children falls on the mother, if you wait for him to make a decision before you know it, you are already pregnant’.

Adult Women, FGD – Bungoma County

‘It’s a woman’s decision because men do not have the time and some of the men are drunkards and irresponsible’.

Heterogeneous Group – Nyeri County

‘If your husband comes home during weekend or end month, you do not have time to discuss these issues, so it is our decision’.

Adult Women FGD – Tharaka Nithi County

It is evident across the regions that some men make key decisions on the use of family planning and reproductive health services. The respondents argued that men are the heads of the family, main economic providers, and final decision makers. This view was commonly held by both the young

and adult men. The findings show that some men practice family planning for fear of being ridiculed by their peers over large families. The following excerpt illustrates this:

“For instance when you have repeated pregnancies, he doesn’t tell you directly, he will tell you to go to so and so to show you what she does to space children or warns you that if you get another child it is your problem”

Adult Women, FGD – Kairugu

Some of the respondents stated that the decision to use family planning FP/RH services rests with husband and wife.

“Children belong to both man and woman and the responsibility of bringing them up is for both”

Young Women, FGD, Machakos County, Lower Eastern

In few instances, the role of mother-in-law in decision making on FP/RH was mentioned. It was noted that some couples find it difficult to plan their families due to pressure from the in-laws; who in most cases prefer many children.

5.4 Preferred Role for Men

Most studies have shown that one of the most common reasons for none use of FP/MCH services is lack of spouse/partner support. The 2014 Male Involvement survey sought to establish the role that men should play in family planning and maternal and child health. The findings are based on views of both men and women respondents. Some of the identified roles include:

- Accompanying spouses to the clinic. It was mentioned in a third of the clusters and particularly among young male and female participants.

The findings further reveal that men should:

- Provide psychological and moral support to their spouses during pregnancy and child birth.
- Discuss with their wives about FP, MCH care and accompanying their wives for services.
- Give financial support to meet the health needs of women and their children.
- Educate their peers on FP/RH including young people in preparation for marriage.
- Assist in household chores and support their spouses before, during and after delivery.

5.5 Community Recommendations for Enhancing the Role of Men in FP/RH

Majority of young people reported a general lack of family planning mentors and role models. Programmes should identify and build the capacity of community role models to mentor the young people.

The results show that generally men have inadequate information on family planning and maternal and child health. It was observed that programmes have not adequately targeted men with family planning and reproductive health information and services. Programmes should therefore seek to create awareness among men on the importance of family planning and their role in it.

5.6 Spousal communication

The findings show that there is limited couple communication on family planning and reproductive health issues which hampers male participation. There is need therefore for reproductive health programmes to target couples in order to enhance spousal communication on reproductive health issues. The findings indicate that majority of men in most communities are uncomfortable accompanying their spouses for family planning and maternal and child health services because of cultural and gender norms. Further research is therefore necessary to provide a basis for the design of innovative strategies to address community specific barriers to male involvement.



5.7 Key Findings and Recommendations

1. Key findings

- Men have an important role to play in FP/RH. They are widely recognized as heads of households in the communities.
- Although men make key decisions on the use of FP/RH services; their main role is to provide financial support (transport) to their spouse to seek family planning and maternal and child health services.
- Generally men have inadequate information on family planning and maternal and child health.
- There is limited couple communication on family planning and reproductive health issues which hampers male participation.
- Although majority of women reported that they make decisions on the use of FP/RH services, they were in consensus that the decision should rest on both husband and wife.
- Majority of men in most communities are uncomfortable accompanying their spouses for family planning and maternal and child health services because of cultural and gender norms.
- Family planning and maternal and child health are widely considered a woman's responsibility.
- Role of men in family planning and maternal and child health is affected by the prevailing myths and misconceptions.
- Fear of stigmatization is widely associated with male methods of family planning (vasectomy).
- Majority of young people reported a general lack of family planning mentors and role models).

2. Recommendations

- There is need for programmes to identify , nurture FP mentors and champions to be role models especially to the young couples.
- Programmes should design targeted IEC materials for all groups of peoples/audience and use appropriate channels of communication.
- Programmes should target couples to enhance spousal communication.
- There is need to have programmes targeting men emphasizing their role and involvement in FP/RH.



Chapter Six Barriers to male involvement

Chapter Six: Barriers to male involvement in family planning (FP) and maternal newborn child health (MCH)



One of the main objectives of this survey was to identify the barriers that contribute to the low male involvement in FP and MCH. This chapter presents the main barriers to male participation as mentioned by survey respondents and provide important insights on how to enhance male participation.

6.1 Individual Barriers

6.1.1 Inadequate Information and Knowledge on FP and MCH

Inadequate and incorrect information about Family planning methods was identified as one of the main hindrances to use and an impediment to male involvement in Family planning.

The survey results also show that there is low male involvement in maternal and child health care services. This is attributed to inadequate knowledge and understanding of the services and low literacy levels among some men and women. Most men are ignorant about FP methods and have limited understanding on the importance of MCH. This delays the seeking of health services.

6.1.2 Myths and Misconceptions on FP methods

Myths, misconceptions, and fear of side effects of FP were reported virtually in all FGDs as one of the deterring factors that cause some men to restrain their spouses from using contraceptives. The most commonly reported myths and misconceptions are that: contraceptives contribute to promiscuous behaviour, low libido, infertility, cancer and birth defects. Some of the common side effects of FP methods cited include; heavy bleeding, weight gain,

irregular periods. A male participant in Nyandarua expressed his concern thus:

'We mentioned rumours such as taking pills leads to loss of interest in sex, use of injectables cause a woman's body to lose shape giving her a bloated shape, loose hanging flesh while her feet swell for using the pills- and she can no longer fit into her usual shoes. As a man, you don't wish to interfere or mess with your spouse's shape or body. So the rumour on side-effects is itself a barrier- you may not readily accept such FP method as pills. And so when the provider at the local health facility, who is well known to me, may let the cat out of the bag and say the pills or injectables are responsible for the changes in my spouse... This is a barrier in itself; it is responsible for the fear of going for FP.'

Adult Men, FGD – Murungaru, Nyandarua County

6.1.3 Social (psychosocial) issues

The analysis of FGD data shows that social issues of spousal communication, absentee husbands, alcohol abuse and peer influence are key contributing factors that impede men involvement in FP and

MCH. Majority of participants in nearly all regions reported the following social issues that hamper male involvement in FP and their participation in Maternal and Child Health care:

6.1.3.1 Poor Spousal Communication

Lack of proper communication between couples always leads to mistrust and affects their health seeking behaviour. Men in more than half of the regions reported that they do not talk about clinic visits and Family planning with their wives because they assume that it is a woman's business. Others complained that their wives go for these services secretly without informing them. Even during times of delivery pregnant mothers in most of these areas are accompanied by other elderly women in the neighborhood while men only organize for transport.

Data in some regions such as South Rift, North Rift and Coast show that young women married to older men, with a wide age difference between them, have lower decision making powers with regard to utilization of FP and Reproductive health services compared to their older counterparts. The results show that their husbands or mother-in-laws are final decision makers. This causes delays in seeking for these services because they have to seek permission.

'The young people have a problem because you find the man marries a nineteen year old girl and he is twenty five, they stay and the girl gets her first child. It is very hard for such a young person to start telling the husband that she wants to do family planning because the boy might think this girl want to either leave him or start seeing other men, in this case'.

Young Heterogenous, FGD – Narok County, South Rift

In almost two-third of the regions, young women raised concern that their husbands are hardly at home. Either they work far from home or come late in the night, having no time to be involved in FP or MCH discussions. This was summed up in this statement.

'Normally, most of the men in the society are the sole breadwinners in the Family. So if a man goes to the shamba, he tills all day long, by the time he comes back he is exhausted and he has no time to talk of FP because he is just thinking of how he is going to start from the following morning. Secondly, if a man is employed, he leaves early and comes home late. He does not have a part to play. What he comes home for is to have supper and have a peace of mind before waking up for his boss's job'.

Adult Women, FGD – Nyamira County, Nyanza South

Women participants in more than two-third of the regions reported that some of their husbands are habitual drunkards and irresponsible and thus do not discuss issues with them about FP or maternal and child health. This was commonly cited in Western, Nairobi and Central. As stated by a female participant in Western,

'Our men wake up very early and go to work, even those that do night shifts do not have time. When they leave work they go to take traditional brews and come back home drunk and we cannot discuss anything'.

Adult Women, FGD – Bungoma County, Western

6.1.3.2 Peer and Family Influence

Majority of the young married women in almost a third of the regions expressed their concern that

most of their husbands are influenced by their peers to oppose use of FP. According to a participant:

'You can agree with your husband to use an FP method and he embraces the idea but later on he comes home and harshly insists you discontinue because he has heard they are not good they make women to be promiscuous or it switches off the lights in women and makes them disinterested in sex.'

Young Women, FGD – Nairobi County

Parental influence particularly mother-in-laws were mentioned by some female participants as encouraging their sons to oppose FP. A young female participant said:

'If a woman has only girls or one child, the mother-in-law will keep complaining taunting her "what you are waiting for, you are only giving us girls or given us one child?'

Young Women, FGD – Kisii County, Nyanza South

6.2 Cultural and Religious barriers

Survey findings show that use of contraceptives is not allowed in most of the communities in Coast, Central Rift, Nyanza, Western, Eastern North, North Eastern and North Rift because of their cultural and religious beliefs and practices. For the majority of these communities, polygamy is a lifestyle and co-wives compete to have more children and of either sex. The men in these communities oppose the use of contraceptives because of cultural values such as the need for larger families and naming children after the dead.

'The other barrier is when a man has two wives. They agree to use FP method but one will keep on siring children. So the one who is using FP is forced to discontinue and bear more children, so they keep giving birth.'

Adult Women, FGD – Kisumu County, Nyanza North

'The Gusii culture that the man is the head of the Family is another barrier. Because of this, he will not want to listen to whatever suggestion that comes from a woman however constructive it will be. So, he can rubbish any good idea/advise that the woman will bring forth because he knows that he is the head. You know a woman can go to a seminar and come with an idea which if you ignore, you will perish.'

Adult Men, FGD – Nyamira County, Nyanza South

To some, particularly the Muslims, Catholics and conservative religions like Akorino, they encourage the use of natural or traditional methods of Family planning because their religion forbids modern methods, though they allow for child spacing.

'Our religion does not allow for artificial contraceptives but allows natural methods. The rhythm method is hard to use and many do not understand.'

Adult Heterogenous, FGD – Embu County, Central Eastern

The need to have more children is also currently being perpetuated in some of these communities for political reasons. Most respondents in the FGDs conducted mentioned that there is a growing need to increase in number, so that they could have more of their own to assume political office.

‘Everyone here has more than one wife and they compete to have children of different sexes. We encourage our women to give birth for survival of our clan; we are very few here and hold no political office’.

Adult Men, FGD – Homa Bay County, Nyanza North

Findings from the survey especially from male respondents observed that use of family planning methods by their spouses encourages promiscuity. These sentiments were shared by most men in the areas where the survey was conducted. A male respondent in Nyanza south asserted that:

‘Men feel that, if their women use Family planning methods, then they will be involved in extra marital affairs’.

Adult Heterogenous, FGD – Nyamira County, Nyanza South

6.3 Health Service Barriers

The participants raised the following concerns about health services as a key factor that is reducing the chances of men participating in FP and MCH:

6.3.1 Cost of Services

The cost of services was not dominant in the discussion over FP service but highly mentioned in MCH service by many of the FGD participants. The costs for MCH services were considered prohibitive by men in North and South Rift, Nyanza, Western and North Eastern regions. A male participant in South Rift reported:

‘Your wife wants you to do something, but you are unable for lack of finances and there is nowhere to borrow funds from. Since you cannot afford those maternity services and transport for the two of you. You just tell her to go to nearest government hospital that is free’

Adult Men, FGD – Narok County, South Rift

6.3.2 Slow Service and Long Waiting time

Another issue raised by majority of discussants and key informants is that long queues and slow services at health facilities contribute to low male involvement. Health providers were accused of taking long breaks, talking a lot, and showing little concern to male clients who have to return to work. One young female participant said:

‘When you go there with your husband, you wait in the queue until he starts complaining that he needs to go back to work. Your husband will feel sad to leave you unattended, so he will wait but then he will go home annoyed and lamenting and will never accompany you to the clinic again’.

Adult Women, FGD – Kakamega County, Western

6.3.3 Inadequate Supply of FP Commodities and Drugs

According to majority of participants of the FGDs and exit interviews, inadequate supply of contraceptives and essential medicines is also one of the main reasons behind the general dissatisfaction of quality of services reported in most regions, hindering utilization of health services by male clients. The need to avail FP methods for men was

cited in more than a third of the regions. Male participants insisted that service providers should innovatively promote male acceptable FP methods.

6.3.4 Service Provider Attitude

About two-thirds of the FGDs and exit interviews revealed that health providers in some facilities were unfriendly and prejudiced. They were reported to turn away male clients who accompany their wives to clinics. They also breached their confidentiality by discussing clients' choice of methods with fellow providers or other community members. Participants cited the following concerns:

'I went with her to that facility and they told me to wait outside, that it is a woman who can plan not me and there are no medicines for men to plan'.

Adult Men, FGD – Kitui County, Lower Eastern

'There is a provider who tells people that so and so has done Family planning or has done vasectomy and you know men don't like it when their confidentiality is broken'.

Adult Heterogenous, FGD – Nyamira County, Nyanza south

People with disabilities also voiced their concerns in about a third of the regions. One participant was denied a service at a health facility on account of disability:

'I was with my young wife and we went for a method and the health worker attended to others but refused to attend to my wife because she is disabled. The provider thought she is not fit to use any Family planning method. I was annoyed with the nurse and I have never gone back there again'.

Adult Men, FGD – Kwale County, Coast

6.3.5 Inadequate Male FP/MCH Service Providers

Analysis of the FGDs revealed that in nearly all regions, inadequate male providers for FP and MCH services is a serious concern that bars men from accessing these services. Many are disappointed when they come to the facility and find only female providers who are unfriendly and moody. Community health workers are also sometimes female providers.

6.3.6 Facility Layout and Accessibility

Lack of a good facility layout that is easily accessible with proper counselling rooms and waiting space to accommodate male clients was cited as a considerable concern to FGD participants in more than a third of the regions. Similar views were cited by health providers and exit interviews respondents. A health provider in Kilifi stated:

'Lack of proper counselling space for couples affects the quality of service provided and this in most cases deters male clients from coming back for the service'.

Service Provider – Kilifi County, Coast

6.4 Policy and Programme Barriers

6.4.1 Existing policies on FP/RH

To assess the extent to which policies and programmes are a barrier to Male Involvement in FP/RH, a review of some of the existing policies on FP/RH were carried out. These policies included: The National Reproductive Health Policy (2007),

The National Reproductive Health Strategy (2009 – 2015), The Adolescent Reproductive Health and Development (ARHD) Policy (2003), The Family Planning Guidelines for Service Providers 2010, Population Policy for National Development, 2012, Reproductive Health Communication Strategy, 2010-2012, National Guidelines for Provision of Youth-Friendly Services, 2005 and Kenya HIV and AIDS Prevention and Control Act, 2006.

Key informant interviews were also conducted with the County Directors of Health and the In-depth Interviews with medical personnel in-charge of health facilities visited during the survey. These interviews focused on FP and RH policy and programme issues including the existing policy environment, implementation and impact of FP and RH policies, information management, challenges, and recommendations for enhancing male involvement.

6.4.2 Policy Environment

The opinion of the County Directors of Health on male involvement in FP/RH issues in their counties were gathered through the survey. There was a general consensus by respondents from all the counties that Male Involvement in FP/RH issues was very low.

It was generally reported by respondents from all counties across the country that the only policies or guidelines that exists in the counties are those that have been cascaded to the counties from national government which were in place long before the counties were established. Additionally, the policies/strategies/guidelines being implemented in all the counties across the country are all concerned with provision of FP/RH services to the woman and not the man.

In majority of the facilities visited, the service providers interviewed expressed some awareness of existence of the policy documents. However,

the degree of awareness depended on the level of the facility and the position of the person interviewed. Some respondents indicated a high level of knowledge about the policy documents. It was noted that in these documents there are no sections addressing male involvement in FP.

6.5 Ways of addressing Barriers to Male Involvement

The following were recommended as actions to promote male involvement in FP and MCH in Kenya.

i. Involving male health providers in FP/MCH service delivery

Most male FGD participants said they prefer to find male FP/MCH providers at the facility as this is one of the ways of breaking the notion that FP is a woman's issue. They will also feel free to discuss about FP methods with them. The government through MoH and FP/RH partners should increase the number of qualified FP/RH male health workers particularly in rural regions. This is likely to encourage more men to accompany their spouses as well as seek FP and RH services

ii. Addressing the Knowledge gap

Myths and misconceptions about FP methods is another pervasive factor that was said to impede male involvement. Lack of knowledge about FP methods and importance of MCH on the part of men was the main contributing barrier. Public awareness campaigns on FP/MCH targeting men should be organized in all regions to educate them on FP methods and the importance of MCH.

iii. Client friendly services

Majority of male clients interviewed at health facilities during exit interviews pointed out that a less congested, clean facility with space for them

and enough friendly service providers is an ideal condition for male support. Health facilities should be upgraded to attract male clients in terms of counselling rooms, enhanced privacy, waiting space and cleanliness. The facilities should be supported to provide an attractive health package to include male friendly services like prostate cancer screening, diabetes and Blood Pressure monitoring which can be provided to them as they wait for their partners. There is also need to train health workers on male involvement in FP/MCH so that they can provide male-friendly services and promote the participation of male clients.

iv. Improved access and affordability of FP/MCH services

Health care services should be made more accessible, affordable and attractive to male clients through fee waiver schemes, health insurance, cash transfers, outreach, and infrastructure improvement. These should also include disability-friendly services to address the plight of persons with disabilities.

v. Couple counselling for FP/MCH

Findings show that lack of couple communication on FP/MCH issues contributes to low male involvement. Programmes should organize seminars for men and women and sensitize them on the need for spousal communication and the importance of FP and MCH services. Programmes could tap into social networks of women and men's groups and use them as avenues for passing FP/MCH messages.

vi. Improved and targeted information delivery channels

Apart from media, FP/MCH campaigns should utilize other avenues of communication to pass FP/MCH messages to men; functions such as customary ceremonies, weddings, funerals, barazas and also mobile SMS. Media Advertisements on FP should

also target men and package appropriate messages that encourage male involvement in FP/RH.

vii. Integration of FP in development projects

FP programmes should devise innovative ways of integrating FP/MCH information at work places to target men who rarely have time to accompany their spouses for services.

viii. Community Engagement in developing appropriate/targeted IEC messages

In order to raise the level of male involvement, enhance couple communication and increase awareness on importance of FP/MCH there is need to work together with communities to strengthen IEC and social mobilization. This will also help to address cultural practices and beliefs impeding male involvement. The community based health programmes built on established community structures should also be strengthened to effectively address cultural barriers.

ix. Initiation of Male RH empowerment programmes at community levels

Programmes should target empowering male role models or champions at the community and facility levels, who can advocate for male participation in FP/RH by encouraging their peers or clients to get involved. Outstanding FP/RH champions at county levels should be recognized through annual awards. Such awards will recognize their contribution to male involvement in FP/RH.

6.6 Summary of Key Findings

v. Individual Barriers to Male Involvement

- Incorrect and inadequate information Information and Knowledge on FP/ MCH was reported as a major barrier to male involvement.
- Health concerns based on myths and Misconception on certain methods of Family planning. Some of these include:

‘Use of FP methods causes health complications, infertility among women. Women are therefore discouraged by their spouses not to use the FP methods’

‘Men believe that use of FP methods by their spouses promotes promiscuity. Men therefore discourage their spouses from using Family planning methods’.

Adult Men FGD Nairobi

- Poor Spousal Communication is a key deterrent to male involvement in almost all regions. Alcoholism and husband absentee was mentioned as a key contributing factor.
- Low male participation according to women respondents in some regions is also influenced by opposition from peers and mothers-in-law.

ii. Cultural and Religious barriers to Male Involvement

- Care giving, household tasks and Family planning is strongly guided by cultural and gender norms in majority of the communities.

- Cultural values such as desire for more children, sex preference for male child, and survival of children was reported mostly in rural areas as a barrier that stifles the support of male involvement in FP/MCH.
- Religions including Traditional, Catholicism and Islam were mentioned across the regions as a barrier that deters male support.

iii. Health Service Barriers

- Inadequate Male FP/MCH Service Providers at health facilities is a key limitation to male participation.
- Cost of FP/MCH services is considered prohibitive by men.
- Slow Service and Long Waiting time at service delivery points is an impediment to male involvement.
- An unfriendly service Provider is not supportive of male engagement.
- Inadequate Supply of FP Commodities and essential drugs in health facilities creates dissatisfaction and hinders male practice in FP/MCH.
- Current health facility design layout (waiting area, counselling space) is not supportive of male involvement.

iv. Policy Barriers

- The FP and RH policies and strategies being implemented at the county level are those that were developed at the national level, without proper dissemination.
- Awareness of FP and RH policies is generally low among service providers especially in the private sector.

6.7 Recommendations for enhancing male involvement in FP/RH

Recommendations

- Address the knowledge and information gap among men in FP/RH by educating and sensitizing men on importance of FP/RH services to address their health concerns and demystify myths and misconception about FP.
- Use of Innovative FP communication approaches targeting men involvement in FP/RH particularly in areas where cultural and religious practices are prevalent. Emphasis should be placed on use of FP and good birth spacing as efforts of promoting health for individuals and the community.
- Use of men as change agents in FP/RH is reported to be a successful approach that has the potential to promote male involvement.
- Use of mass media to disseminate adequate information on FP methods particularly the less popular methods should be explored fully.
- The only two contraceptive methods available to men; condoms and vasectomy are unpopular. Most women and men are opposed because of fear of mistrust in marriage. Efforts should be made to popularize these methods as effective FP methods.
- Development of county specific policy/strategy/guidelines on male involvement in FP/RH programmes/services should be strategically applied.
- Increase the number of male service providers trained on the provision of quality FP/RH services.
- The county government should be advocated to allocate more resources for provision of male-friendly FP/RH services.
- Involvement of more male health workers as community health workers in the provision of FP/RH services would contribute to enhancing men's access to these services.



Chapter Seven

Policy and Programmatic issues

Chapter Seven:

Policy and Programmatic issues



This chapter presents the findings of the key informant interviews conducted with the County Directors of Health and the In-depth Interviews conducted with medical personnel in-charge of health facilities visited during the 2014 MI survey.

These interviews focused on FP and RH policy and programme issues including the existing policy environment, implementation and impact of FP and RH policies, information management, challenges, and recommendations for enhancing male involvement.

7.1 Existing Family Planning and Reproductive Health Policies

The Government of Kenya has developed a wide array of policies, strategies and guidelines that address issues of reproductive health and family planning. These documents have guided the course of procedures and actions that are intended to influence and determine decisions, and other matters related to programming for health and development. Some of the key documents relevant to Reproductive health/Family Planning include the following:

The National Reproductive Health Policy (2007)

This is the first National Reproductive Health Policy and it provides a framework for equitable, efficient, and effective delivery of high-quality reproductive health (RH) services throughout the country. The policy emphasizes reaching those in greatest need and most vulnerable.

The National Reproductive Health Strategy (2009 – 2015)

This strategy provides clear guidance and is aligned with the National Reproductive Health Policy, 2007. It states Kenya's commitment to the achievement of the ICPD and MDG goals, as well as other international development goals and targets. It also identifies priority actions through which the adverse reproductive health outcomes, including those related to the impacts of the HIV and AIDS pandemic will be reversed.

The Adolescent Reproductive Health and Development (ARHD) Policy (2003)

This was the first policy in Kenya to focus on improving the reproductive health and well-being of adolescents and youth. Currently, plans are underway to review this policy to incorporate the new emerging issues. Towards this, an implementation assessment was conducted in 2011/12.

The Family Planning Guidelines for Service Providers 2010

This is the fourth edition and reflects the current policy and training guidelines for providing FP services, especially with regard to the integration of FP and the various RH and HIV/AIDS programmes and services. It incorporates the most recent

information on Medical Eligibility Criteria (MEC) for the use of various contraceptives, and covers a wide range of medical conditions as published by the WHO (2009).

Other important documents include:

- National Guidelines for Provision of Youth-Friendly Services, 2005.
- Kenya HIV and AIDS Prevention and Control Act, 2006.
- Kenya Vision 2030.
- Reproductive Health Communication Strategy, 2010-2012.
- The Constitution of Kenya, 2010.
- Kenya Health Sector Strategic Plan III, 2012-2017.
- Population Policy for National Development, 2012-2030.

Implementation of these policies and programmes is at different stages and has resulted in various achievements in provision of services and can be verified by indicators such as the decline in fertility – from an average of 8.1 children per woman in 1977 to 4.6 in 2008/9, among others. This has been implemented jointly with other stakeholders including NGOs.

In addition to these policy and programme documents, the Ministry of Health has prescribed registers for recording RH/FP services at the facility level. The information gathered is ideally submitted to the National Health Management Information systems.

7.2 Perspective of Male Involvement in FP/RH

The opinion of the County Directors of Health on male involvement in FP/RH issues in their counties were gathered. There was a general consensus

by respondents from all the counties that Male Involvement in FP/RH issues was very low. This was attributed to an old age belief that ‘FP is a woman’s affair and not a man’s affair’.

7.3 Integration of Male Involvement in the County Plans

This section describes information from the respondents on whether Male Involvement in RH/FP issues are planned for in the county development plans and whether the MI issues are factored in the county health strategy, implementing policies, in terms of having a budget line for male involvement, supervision and monitoring.

In all the counties it was reported that FP/RH programmes are factored in the county health strategy but not on specific issues of male involvement. All the counties do not implement policies that are centered on MI issues and the budget that exists is a lump sum amount for FP/RH issues but not specific to MI issues. Most counties reported a willingness to set aside funds in future to be used in implementing activities geared towards involving men in FP/RH issues within their counties. Such funds would also cater for supervision and monitoring the implementation of the activities in the future.

7.4 Policy Environment

This section sought information on what FP/RH policies, strategies and guidelines are in place at the county level to address issues on MI in FP/RH issues.

It was generally reported by respondents from all counties across the country that the only policies or guidelines that exists in the counties are those that

have been cascaded to the counties from national government which were in place long before the counties were established. Some counties, for example Bomet, Kiambu, Elgeyo Marakwet, Meru, and Embu have come up with county specific strategy to involve men in FP/RH issues. One such strategy is congratulating husbands who accompany their wives to health facilities for FP/RH issues and giving them certificates and allowing their wives to be served first. The women who are not accompanied by their husbands are given letters to take to their husbands requesting them to accompany their wives next time they will be going to the facility for FP/RH services. In Kitui county, it was reported that no priority is given to men who are seeking FP and RH services. The respondents from all counties were in agreement that there is need to domesticate national policies and guidelines at county level to come up with county specific policies and guidelines.

7.5 Existence of Policies/ guidelines at Facility level

This section sought information on whether the national policies and guidelines are being disseminated to the facility level.

7.5.1 County level

The policies/strategies/guidelines being implemented in all the counties across the country are all concerned with provision of FP/RH services to the woman and not the man. Strategies to involve men in FP/RH programmes are just being initiated in some counties. This involves domestication of the national documents that are already in existence. Some of the constraints envisaged in involvement of men in FP include shortage of staff in all levels of health facilities, inadequate equipment and stock out of supplies at certain times; inadequate supervision and lack men friendly services.

7.5.2 Facility level

At majority of the facilities visited, the service providers interviewed expressed some awareness of existence of the policy documents. However, the degree of awareness depended on the level of the facility and the position of the person interviewed. In almost all District Hospitals, where those in charge of the facility were interviewed, they mentioned that the policy documents are available from ministry of Health Headquarters. Elsewhere, some of the respondents from private health facilities said that they were not aware of the documents.

Understanding of the contents of the documents was low since most respondents could not explain properly whether the documents contain sections that address male involvement. Some respondents indicated a high level of knowledge about the policy documents. It was noted that in these documents there are no sections addressing male involvement in FP.



7.6 Implementation of Policy documents

In the majority of the facilities visited, the policies are well followed with some reporting that the policies do not address male concerns. However, almost all but a few facilities give first priority to men who visit the clinics whether alone or accompanying their spouses. Some of their sentiments are quoted below:

‘When we get clients, there are some examinations we do e.g. we take their weight, blood pressure, and other medical conditions, we check their medical history and do FP counselling. That is an approach we use but the client can choose some of the things we do and then maybe on their return date we give them a small card that they take home and come back for the FP at the right time’.

Health Facility In-charge

A few providers reported that all clients are treated equally and no preference is given – “we don’t give them special treatment” and the services are on “first come first served basis”. In addition, some of the respondents were able to outline some guidelines that they follow using the national policy documents.

7.7 Impact of policies

Majority of the facilities visited indicated that though men are given priority and do not queue, very rarely do they visit the RH/FP clinics – One respondent is quoted; “Normally when they escort their wives, most of them are those whose wives have bad obstetric history e.g. birth complications” and in other isolated cases, they escort the wives to the hospital but very rarely do they wait until birth.

‘Men do not come for normal routine checkup but they only come when they have problems’.

Health Facility In-charge

Due to the low turn up of males in the RH/FP clinics, most of the facilities are using other approaches outside the laid down policies to attract the males. These include urging women to bring their husbands as noted below:

‘Problems are easily solved when they are counseled together. When the husbands come to pick their wives from maternity, some of them, you find that the wife has a high parity, so we capture that opportunity to tell the husband that it is wise if they space so that mama (mother) does not get pregnant so soon’.

Health Facility In-charge

Some of the interventions are assisted by stakeholders e.g. Marie Stopes, APHIA Plus, and World Vision who offer outreach services apart from providing FP commodities and services.

7.8 Information Management

This section sought out information usage of the registers, information that is captured in the data collection tool, reporting structures and information utilization at county and facility levels.

7.8.1 County level

The tool that is used is 731 register which most of the respondents in all the counties reported as being easy to use. The information collected through this tool are; clients details that includes name, age, sex

and marital status, type of method the client wanted and the one provided and whether counselling was done. The information obtained through this tool forms part of the Health Management Information System (HMIS). The reporting is from the facility in-charge to the sub-county officer who then reports to county officials. The reporting is done on monthly basis from all counties and across the board it was noted that it assists the county officials in planning and in carrying out supervision.

7.8.2 Facility level

Every facility visited reported that they normally record all RH/FP information regarding the clients



who visit their clinics. They were all aware that the information is recorded in the registers that are provided by MoH. The information recorded includes name of client, age, sex, client first or a revisit, residence, and type of method given and also TCA (when to come again). However, some of the respondents were not sure of all the variables recorded like the marital status – some respondents said that “Marital status is in maternity register”.

In addition, all the respondents were unanimous that the data collected is submitted every month. After the report has been generated at facility level, it is analyzed and entered in the DHIS (District Health Information System) and then sent to the DHMT (District Health Management Team) every month. In addition, most of the respondents were aware that the data is finally entered into the Health Management Information System (HMIS).

Regarding utilization of the data at facility level, majority are aware that the data is used for planning and monitoring. Some of these sentiments are quoted below:

‘We usually have a meeting we call Continuous Quality Improvement meeting every first Friday of the month so that we can analyze the data from the previous month and we have representatives from all departments. We analyze how many clients we were able to see, how many services we were able to offer, what the constraints are and if the commodities were available. We explore quite a number of options from which we are able to come with a way forward. We are able to plan; if we should ask for more staff, if we need to allocate more funds to a particular area or if we need to take people for training for people to acquire knowledge in certain areas’.

Health Facility In-Charge–Nairobi, County

At the community level, the data is similarly used for planning and monitoring with other stakeholders. The data has been useful in addressing areas that require more resources, awareness and advocacy creation on RH/FP services. This is normally as a result of sharing the gaps and the challenges identified in the daily running of service provision. If a particular partner feels they can assist, they take up some of the interventions. The data is also used by external researchers.

7.9 Challenges

This section highlights the major challenges that hamper implementation of the policies/strategies/guidelines on male involvement in RH/FP at County and facility level.

7.9.1 County level

In all the counties it was reported that the documents they have are the ones they inherited from the national government where only a few copies were available. This makes it difficult to make the copies available to all the service providers as it is only possible to have copies at facility level. It was also reported by all the counties that service providers had an attitude problem besides lacking the necessary skilled required to provide certain FP methods that may be preferred by the clients. In some cases it was reported that service providers had little knowledge of the full range of methods mix that are available in the market.

7.9.2 Facility level

All facilities visited indicated that they have diverse challenges in provision of RH/FP services. These challenges are either facility based or client/community based. Some services such as vasectomy and BTL are not offered in most of the facilities.

Challenges contributing to this include inadequate staff, lack of skilled staff to conduct the operations, lack of privacy in RH/FP clinics and lack of adequate supplies. Lack of male nurses in FP clinics was cited as a key challenge in Maasai land since the culture does not allow women to address men unless in special occasions.

Community myths and perceptions have also largely been blamed for poor involvement of men in FP. For instance, it was mentioned that in the same culture, during FP barazas, when you talk about FP, men walk away – “They do not want to hear about vasectomy”. In addition, women want to conceal their uptake of contraceptives even to their husbands in many communities as one facility in-charge reported:

‘Mothers come secretly so that their spouses won’t know. The injectables receive the highest uptake since they are discreet in the sense that once taken the woman doesn’t need to come back soon and cannot be observed by the spouse unlike pills which they fear that their men will see them taking daily’.

Facility In-charge

7.10 Opportunities

This section was seeking to establish the extent to which different sectors within the county government are involved in implementing male involvement in FP/RH policy/strategy/guidelines documents. In all the counties the policy makers reported that there is limited multi-sectoral engagement in the implementation of the documents that are concerned with involvement of males in FP/RH programmes in the counties. This was acknowledged, noting that they are just setting up structures at county level hence not possible to

involve everybody but they all agreed that multi-sectoral approach would be the way to go if males are to be fully involved in FP/RH programmes.

The opportunities that were reported by the counties as existing that would promote male involvement in FP/RH issues are; population in the counties who are willing to learn and are welcoming to new concepts, new constitution that has devolved the provision of health services in FP/RH services, a number of NGOs, FBOs, and development partners who are willing to embrace multi-sectoral approach in the provision of health services including FP/RH services.

Some of the facilities visited reported to be getting some form of external support mainly from NGOs. The commonly mentioned NGOs include Marie Stopes, APHIA Plus, Tupange, PSI, Pathfinder and World Vision. These stakeholders have largely concentrated their activities in areas where most health facilities have challenges. These provide services including provision of long term methods of family planning, performing cancer screening, and to a lesser extent outreach services.

7.1.1 Proposed Recommendations by Respondents

The respondents were asked to provide recommendations to improve male involvement in FP/RH programmes/services. The respondents at the county level gave an array of views on how to improve male involvement in FP/RH programmes/services in the counties as:

- Development of county specific policy/strategy/guidelines on male involvement in FP/RH programmes/services.
- Capacity building for health service providers on the provision of quality FP/RH services.

- Strong Monitoring and Evaluation system to enhance supervision and feedback.
- Involvement of all stakeholders/sectors in issues of Male Involvement in FP/RH programmes/services.
- Allocation of adequate resources for FP/RH service provision and specifically for male involvement in FP/RH programmes/services and making available a wide range of FP methods while averting stock outs.

At the facility level, most of the respondents indicated that they lack skilled personnel to perform long term methods of FP and they recommended:

- More training for their staff or increase in number of staff.
- Involvement of male health workers in the provision of FP/RH services.

Most facility in-charges mentioned that the current infrastructure at the RH/FP clinics is not conducive for men and need to be redesigned. Areas that need to be addressed include expansion of existing space, construction of rooms with more privacy and construction of a separate room for men who visit the clinics alone.

Increase community awareness on importance of male involvement in RH/FP. Lack of awareness on RH/FP by men was largely mentioned as a key impediment in their involvement at the clinics. The recommendation is to increase community awareness through outreaches, media, religion, public barazas and market days. One of the facility in-charge in Narok county said that to reach more men, it is important to intergrate the FP/RH with development matters, for example in Narok “*chimba maji kwanza*” meaning that men can be very easily accessed at water points when they take their cattle for water. Also, the mothers should be encouraged to bring their spouses during the visits. One facility in-charge mentioned that even

the name of the facilities (MCH) is not men friendly and recommended that it be changed to family health clinic. His sentiments are quoted below:

‘Changing the name of MCH is another recommendation; from MCH to family health. The name is not friendly to men so it should be changed to family health. It could also help if we put in place a policy that when a woman is accompanied by the man for FP, child immunization or ANC they are given first priority. An enticement like that would create a platform to get more men involved in FP and MCH.

Facility In-charge – Mandera County



Some areas visited mentioned that men do not visit the facilities due to their busy daily chores. They recommended for opening hours to be extended, if possible remaining open on weekends.

Availability of IEC materials was mentioned as an area which needs to be addressed in order to enhance public education on FP and RH. In some cases these materials will require to be developed to incorporate men.

7.12 Key Findings and Recommendations

1. Key findings

- The FP and RH policies and strategies being implemented at the County level are those that were developed at the National level, without proper dissemination.
- Strategies for Male Involvement have not been explicitly incorporated in the County Strategic Plans.
- A multi-sectoral approach by all stakeholders is essential if male involvement in FP and RH needs to be enhanced.
- Human resource shortage and inadequate skills at the facility level are among the main constraining factors affecting FP and RH service provision.
- Awareness of FP and RH policies is generally low among service providers especially in the private sector.

2. Recommendations

- Domestication of national FP and RH policies and strategies at the County level.
- Advocacy for the inclusion of male involvement strategies in the County Strategic Plans. These strategies should encompass a multi-sectoral approach.
- Regular updates and refresher training on FP/RH for more health workers especially in the lower level health facilities. This should be done alongside the recruitment of more health workers to alleviate the existing shortages.
- Sensitization of health workers on the existing health policies and strategies including those on FP and RH.



Chapter Eight
Narrations

Chapter Eight: Narrations for male involvement in family and reproductive health

8

The narrations give different scenarios depicting the advantages of having a well-planned family and disadvantages of large family size with limited resources.

Summaries of Respondents Views: Machakos County

In Machakos county for instance, a couple having six children were reluctant to use family planning methods when they started living together. The wife got pregnant while in school but would have wished to continue with her education after giving birth to her first child. This however did not happen, she soon found herself pregnant again with the second child while the first child was barely eight months. She therefore shelved her dream of going for further studies. After the fourth child was born, she decided to start using a family planning method. At the onset, the man was not supportive of the idea which almost led to the split of the marriage. So she stopped using the method but after the birth of the other two children, life became difficult because of the cost of living. They were struggling to cater for the basic needs of the family. The husband realized something had to be done and he initiated the talk on family planning. They decided she continues with what she had previously used since she did not experience any side effects. The husband became very supportive, he would accompany her and when she is busy, he would go to the service delivery point to pick for her the contraceptives.

The husband is involved in the business of buying and selling of animals. They also farm in a nearby irrigation scheme. This provides income for the family and pays for the needs of the children. The family plans to start saving for the children's future education by opening a bank account and buying additional livestock.

"After the sixth child we agreed as a couple to use family planning, she sends me for the contraception or I would take her to the health to get the contraceptives".

~ Respondent, Machakos



The couple from Machakos with one of their children during the interview.

Summaries of Respondents Views: Embu County

In Embu county a couple having 10 children had desired to have 12 children but stopped giving birth due to the hard economic times. They shared their experience of bringing up a large family. The family owns a small piece of land which due to the current harsh climatic conditions is not agriculturally productive. Hence they are struggling to educate and feed their family. He laments, "the cost of a sack of maize is now Ksh.3500 and I cannot afford it yet my land is not producing anything". The couple have heard about family planning methods, the wife wanted to use but their *Akorino* religion does not

allow. It encourages the followers to follow the scripture that they fill the world. They only use the traditional method of the wife sleeping in a separate room from her husband. They rarely discuss the topic on family planning though they acknowledge the importance of planning for families. They are involved in business and the rearing of goats and cattle, through a project funded by a local Catholic Church. The couple is not planning to get any more children but will continue to use the traditional method of family planning.

"I have five sons and I only have five acres of land, they did not go to school, so they cannot buy their own land so for them they will have one child each".

~ Respondent, Embu



The respondents are a couple from Ishiara, Embu County.

Summary of Respondents Views: Kiambu County

We also visited Zambezi area in Kiambu county and met a couple married from the year 2004. The two are graduates and employed. The man is a banker while his wife is a public officer.

The couple has three children, and live in an urban area. They agreed at the time of marriage to have three children and they stuck to that. Since both of them are working, they are able to support their family. At the start of their marriage the couple stayed apart from each other for some time due to their different work station. Regardless of that they were able to raise a family. They only delayed having a second child because of financial problems.

The couple is well informed about family planning and its benefits. They made a decision to use family planning method after the birth of their second child. They visited a health facility in Nyeri and were counselled on the various family planning methods, including the advantages and disadvantages. Since his wife's blood pressure was extremely high they were advised to stop using hormonal based contraceptives for a while. They resorted to natural method and condoms. But they found it difficult to stick to the methods so they resolved through further consultation to use the permanent method of family planning. At first, the couple was discouraged by friends not to go that route, since most of them reasoned that with time they might desire to have more children. Since they knew what was good for them, they decided to go for a permanent method of family planning.

"Men always think of the big investments but not family planning, but a decision on family planning can affect the big investments that they are thinking about".

~ Respondent, Kiambu



The Kiambu couple with their children during the interview.

The couple raised concern that it is only those that have gone to school have basic understanding of family planning. Those with lower level of education, low income and limited resources have little or no understanding of the benefits of family planning. The couple urges for public education on the importance of male involvement in family planning. The two are involved and usually go together to the health facilities for FP services. They stated that, men always think of big investments but forget that family planning is also an investment. A decision on family planning could affect the big investments that they are always thinking about. So those big investments are determined by the small decisions that we make. The couple plans to invest in their children by buying each one of them a plot of land.

“I would advise them on issues of family planning because I had a problem of planning myself. I would tell them of the many problems I have experienced because of lack of planning. Let us help one another by discussing the good things about family planning”.

~ Respondent, Kilifi



The respondent in her home in Malindi, Kilifi County during the interview.

Summary of Respondents view: Malindi, Kilifi County

In Malindi county we met a lady who is separated from her husband because of domestic wrangles. She is living with her dad together with her sixteen children; six boys and ten girls. Though she got married at very early age, she did not to plan to have that large number of children. She was not using any method of family planning so the children are closely spaced.

The husband was a habitual drunkard who neither provided for the family nor was concerned about family planning. He was always away from the family to avoid responsibility and whenever he was around he treated her cruelly. She left her matrimonial home because of the harsh treatment. She notes that in the village there are no advocates for family planning. So given the opportunity, she would encourage people particularly the young people to embrace family planning to avoid such pitfalls resulting from lack of planning.

Summary of Respondents view: Kisii County

In Kisii county, we meet a couple who live on a small piece of land where they grow Napier grass for sale and also maize on a small scale for consumption. This does not give him enough money to take care of their family of nine children. The greatest problem is school fees. Most of the older children dropped out of school and they look for employment in the village as herds boys. The couples used to drink a lot in an attempt to forget their misery but they have now turned to

God for solace. He notes that his children are very bright in school but because he cannot to pay for their school fees has made things very hard and painful for him.

The couple does not used any method of contraception but have heard about family planning methods. They are planning to start using family planning methods and stop giving birth.

"I have a problem in feeding and educating my family because of the limited resources".

~ Respondent, Kisii



The couple (right) with some of their children and the translator (left) during interview.

Summary of Respondents views: Bungoma County

In Bungoma county a couple has been fortunate to take care of their large family. The man went to school in the early years and has been working for the government before he retired. He had huge track of land which he sold part of it for the maintenance of his family. They believe that dialogue between a man and his wife is important. He has used dialogue in making decisions about many issues that affect the family. He had ten children with the first wife who passed away, and five with the wife he married later on. He is also taking care of the children of her daughter who passed away. He reckons that most men are not involved in issues of family planning and reproductive health because they fear responsibility. They would rather sire children outside marriage, because they do not have means of taking care of them.

Their children are all educated and are currently working while others are still pursuing their studies in various colleges. He asserts that there are strong cultural issues concerning vasectomy as a method of family planning and the Bukusu community does not allow. He says that once a man has undergone the cut (circumcision), it is not possible to use a knife or a razor on his private parts again. The role also of religion is also a hindrance to family planning especially the Catholic Church, which he says advocates for abstinence and does not permit the use of condoms or permanent methods of family planning.

“Most of the young people do not want to marry in the majority of the cases they cannot feed and provide housing. Because of lack of money, they postpone marrying and also fear responsibility”.

~ Respondent, Bungoma



Respondent at his home in Webuye, Bungoma County during the interview.

Moving forward he recommends that information on family planning and reproductive health be availed to all people at the community level to demystify the myths. This will help create awareness on the issue of family planning.

Summary of Respondents views: Turkana County

In Turkana county we meet a polygamous man; a husband to eight wives and a father to 37 children. He reckons he preferred marrying uneducated women because they are easy to handle. He served in the military but dropped out after the death of his father and sister. He married many women while in the military because he had money. His father also had many wives. He is struggling to fend for his large family and regrets having many children. He encourages people to have the number of children that they can easily take care of. The children of all the wives are closely spaced and at times he forgets who is who. Providing for

this children is a great challenge because he depends only on farming. Most of the children are attending school and he is lucky to receive some little support from relatives and other well-wishers who come in to help where necessary.

He heard about family planning while at the military but did not pay attention to it. Now he understands the importance. They have not been using any method of family planning, he has tried the condoms but does not find pleasure in them.

“If I continue giving birth, what will I give them, clothing is a problem, medical is a problem, but this people cannot tell you if they are in the danger days”.

~ Respondent, Turkana



Respondent (left) with part of his family.

References

The main survey tools are found on this link, www.ncpd-ke.org/others

Government of Kenya (GOK), *The Constitution of Kenya* (Nairobi: GOK 2010)

Government of Kenya (GOK), *Kenya Vision 2030; A Globally Competitive and Prosperous Kenya* (Nairobi: GOK 2007)

(Kenya National Bureau of Statistics (KNBS) & ICF Macro. (2010). *Kenya Demographic and Health Survey 2008/09*. Calverton, Maryland: KNBS and ICF Macro.

Ministry of Health, (MOH) (2007). *National Reproductive Health Policy: Enhancing Reproductive Health Status for all Kenyans* (pp1-44). Nairobi. Ministry of Health.

Ministry of Public Health and Sanitation (MOPHS), (2005). *National Guidelines for Provision of Youth Friendly Services, 2009*. Nairobi: Kenya.

Ministry of Health (MoH), (2005). *Reversing the Trends-The Second National Health Sector Strategic Plan of Kenya: NHSSPII-2005-2010*.

Ministry of Public Health and Sanitation, (MOPHS), (2008). *Road Map for accelerating the attainment of the MDGs related to Maternal and Newborn health in Kenya*. Division of Reproductive Health, December 2008.

National Council for Population and Development (NCPD), (2012). *Population Policy for National Development*. Sessional Paper No. 3. Nairobi: NCPD.

National Council for Population and Development, NCPD, (2004). *ICPD+10: Where we are now? Kenya's Progress in Implementing the International Conference on Population and Development Programme of Action 1994-2004*.

National Coordinating Agency for Population and Development (NCAPD) [Kenya] Ministry of Medical Services (MOMS) [Kenya] Ministry of Public Health and Sanitation (MOPHS)[Kenya] Kenya National Bureau of Statistics & ICF Macro,(2011). *Kenya Service Provision Assessment Survey 2010*. Nairobi. Kenya.

NASCOP & Ministry of Health, Kenya, (2008). *Kenya AIDS Indicator Survey 2007: Preliminary Report*. Nairobi, Kenya.

Republic of Kenya, (2009). *National Reproductive Health Strategy 2009-2015*. Nairobi: Republic of Kenya/ Ministry of Public Health and Sanitation and Ministry of Medical Services.

National Council for Population and Development (NCPD), Republic of Kenya, (2003). *Adolescent Reproductive Health and Development Policy*. Nairobi: Republic of Kenya/National Coordinating Agency for Population and Development and Division of Reproductive Health.

World Health Organization (WHO), (2009). *Medical Eligibility Criteria for Contraceptive Use*. Fourth edition.

Ministry of Gender, (2003) *Disability act*, Kenya, Nairobi

Survey Personnel

STEERING COMMITTEE	Technical/Trainers	Support services
Dr. Josephine Kibaru-Mbae, Director General, NCPD	Prof. Joyce Olenja	David Ochieng
George Kichamu	John Anampiu	Taslim Wasom
Vane Lumumba	Samuel Ogola	Maurice Opiyo
Catherine Muoki	Fatuma Dubow	Dorothy Oliech
Dr. Marsden Solomon	Irene Muhunzu	William Ochola
Dr. Bartilo Kigen	Jackline Kivunaga	Lorna Gathua
Nzomo Mulatya	Eunice Njoki	Sam Kingoo
Peter Nyakwara	Francis Kundu	
Charles Oisebe	Catherine Ndei	
Prof. Lawrence Ikamari	Lucy Kimondo	
Margaret Muthoni Mwangi	Faith Atieno Ogolah	
	Stephen Macharia	
	Moses Ouma	
	Alex Juma	

No.	Region	Supervisor	RA Team	Driver
1.	Nairobi	Reinhard Rutto	1. Maureen Olwero 2. John Kagwi	Tsembea Abdala
2.	Central	Fidelis Ndungu	1. Judith Mathai 2. Edwin Mugo	Patrick Manyangi
3.	Central Eastern	Beatrice Okundi	1. Dr. Nkirina Severina 2. John Wachira	Jackson Murungi
4.	Upper Eastern	Seth Omondi	1. Fardoswa Mohammed 2. Mohamednoor Kulumbo	Abdile Mohamed
5.	Lower Eastern	Jane Wanjaria	1. Peter Musyimi 2. Stellamaris Mumbua	Peter Omari
6.	Central Rift	Margaret Kung'u	1. Josphine Wanjiru 2. Nelson Kiprono Bii	Joshua Lagat
7.	South Rift	Enoch Obuolo	1. David Partugas 2. Kelvin Ololdapash	Sief Muturi
8.	North Rift	Rose Wakuloba	1. Timothy Yator 2. Bridgit Ngetich	Wilson Kandie
9.	Nyanza North	Oduor Onyango	1. Jared Magengo 2. Fidelis Monica Aluoch	Ernest Ojoro
10.	Nyanza South	Maurice Oduor	1. Everline Bosibori 2. Evans Nyamwaka	Zachary Atuya
11.	Western	Michael Oruru	1. Peter Wafula Khaemba 2. Elizabeth O. Ocholi	Brenda Wang'a
12.	North Eastern	Ken Lwaki Gao	1. Nima G. Abdi 2. Ali Khalif	Salah Sheikh
13.	Coast	Sammy Tanui	1. George N. Dzombo 2. Margaret Mwaila	Jeffa Chai

MI Apprenticeships	Supervision Drivers
David Musiega Timothy Nyandusi	Josphat Mulira Stephen Munyao Samuel Bett Samuel Oduor





National Council for Population and Development
PO Box 48994 - GPO, Nairobi 00100, Kenya
Tel: 254 20 271 1600/01
Fax: 254 20 271 6508
Email: info@ncpd-ke.org
www.ncpd-ke.org

NCPD is a semi-autonomous government agency that formulates and promotes population policy and coordinates related activities for sustainable development in Kenya.