

**MALE PARTNER INVOLVEMENT IN CONTRACEPTIVE UPTAKE  
AMONGST URBAN SOMALI REFUGEES IN, NAIROBI COUNTY, KENYA**

**BY  
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### DECLARATION

This Thesis is my original work and has not been presented for a degree in any other University.

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## **DEDICATION**

This thesis is dedicated to my Lord, Jesus Christ for His grace and sufficient provision for all that I needed to complete this master's degree. Secondly, my parents and siblings for their support and finally to my children Leon, Dahlia and Dylan. Special dedication goes to my loving husband Boaz Ayoo for the encouragement and financial support.

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**LIST OF ACRONYMS**

<b>ASRH</b>	Asexual Reproductive Health
<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>CHW</b>	Community Health Workers
<b>CDC</b>	Centre for Disease Control
<b>COC</b>	Combined Oral Contraception
<b>CPR</b>	Contraceptive Prevalence Rate
<b>DMPA</b>	Depot Medoxy Progesterone Acetate
<b>ECP</b>	Emergency Contraception Pill
<b>FGD</b>	Focused Group Discussions
<b>FP</b>	Family Planning
<b>GIZ</b>	German International cooperation
<b>HIV</b>	Human Immunodeficiency Virus
<b>IAWG</b>	Inter Agency Working Group
<b>ICPD</b>	International Conference on Population Department
<b>IDPS</b>	Internally Displaced Persons
<b>IOM</b>	International Organization for migration
<b>IUCD</b>	Intra Uterine Contraceptive Device
<b>JRS</b>	Jesuit Refugee Services
<b>KAP</b>	Knowledge Attitude and Practices
<b>KDHS</b>	Kenya Demographic Health Service
<b>MCH</b>	Maternal Child Health
<b>MDG</b>	Millennium Development Goals

<b>NGO</b>	Non-governmental organizations
<b>NFP</b>	Natural family planning
<b>STD</b>	Sexually Transmitted Disease
<b>SPSS</b>	Statistical package for social sciences
<b>UNPD-WCU</b>	United Nations Population Department-Western Carolina University
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	United Nations Commission for Refugees
<b>WHO</b>	World Health Organization

## OPERATIONAL DEFINITIONS

- Contraceptive Prevalence Rate:** The percentage of women between 15-49 years who are practicing any form of contraception.
- Demand for family planning:** A desire or motivation of women or couples to control their fertility.
- Family Planning:** A reproductive strategy that individuals and/or couples employ to meet their reproductive goals.
- Fertility:** the ability to conceive and have children; ability to become pregnant through normal sexual activity.
- Hormonal contraception:** Birth control methods that act on the endocrine system they include DMPA Implants and ECP.
- Intended pregnancy:** A pregnancy that occurred at the time it was expected by the woman
- Intervention:** A deliberate action aimed at influencing a situation of specific importance
- Unmet Need for family planning:** An estimate of proportion of women whose pregnancy was mistimed; amenorrheic women whose last birth was mistimed; and women who are neither pregnant nor amenorrheic and are not using any method of modern family but want to wait two or more years for their next birth.
- Mistimed pregnancy:** Pregnancy that was expected but might have occurred earlier than the woman would have liked.

**Modern methods:**

Modern methods of contraception include female and male sterilization, oral hormonal pills, the intra-uterine device (IUD), the male condom, injectables, the implant (including Norplant), vaginal barrier methods, the female condom and emergency contraception.

**Male involvement in family planning:** Men's participation activities which has the

objective of increasing the acceptability and prevalence of family-planning practice, they include spousal communication and giving permission for contraceptive use.

**Supply of family planning:**

Actual availability and provision of contraceptives as well as family planning information.

## ABSTRACT

Male partner involvement in contraceptive uptake is an important aspect of public health worldwide in the control of the upsurge of populations. Decisions about contraceptive use and childbearing may be confounded by unequal power relations, especially in more patriarchal societies as in the Somali community which emphasizes on male dominance in the culture. Male partner involvement in contraceptive uptake has been shown to greatly influence uptake and continuation rates. According to International Organization for migration (IOM) report of 2010, it indicated that current average use of modern contraceptives amongst urban Somali refugees was 20%, significantly lower than the KDHS report of 2009 at 46% for Kenyan women. The report also stated that the total fertility rate among the Somali population is between 5.7 and 6.7, irrespective of their geographical location. The reproductive health of urban Somali refugees in Nairobi is an important issue for Kenya. Projections indicate that a large number of refugees migrating into towns will become permanent urban residents. The aim of the study was to identify male partner involvement in contraceptive uptake amongst Somali refugees in East Leigh, Nairobi County Kenya. This was a descriptive cross-sectional study utilizing quantitative and qualitative approaches targeting urban Somali refugee male partners living with a woman of the reproductive age in section 11 in East Leigh. Simple random sampling technique was used to get the 255 study participants, who were interviewed using semi-structured questionnaires. In addition, 2 Focused Group Discussions (FGDs) comprising 10 participants each was conducted using the FGD guide. Key informants from the health facility; 1 clinical officer and 4 FP nurses were interviewed using the Key Informant Interview (KII) questionnaire guide. The data from semi-structured questionnaires was analyzed using SPSS version 17.0 software. Descriptive statistics were generated and cross tabulation (Chi-Square test and Fischer's exact test) was done for relationships of variables. Logistic regression was done to assess the effect of various explanatory variables on male partner involvement in contraceptive uptake. The recordings of the FGDs and KIIs were transcribed and main concepts identified. The qualitative data was triangulated with the quantitative data to enhance validity and reliability of the study. The results showed proportion of male partners involved in contraceptive uptake at 79.2%. The following factors influenced male partner involvement: Age when first started living with a woman (OR=3.46, p=0.048), Level of education (OR=3.44, p=0.003), Age (OR=2.76, p=0.044), Knowledge on available contraceptive methods (p=<0.001), The respondents who were aware of some methods that could be used to delay pregnancy had significantly more proportion of male involvement at 81.0% (OR=12.78, P=<0.001), 85.2% of the men reported that men should not be actively involved in issues of contraceptives at (OR=3.44, P=<0.001). In conclusion, information sharing on importance and benefits of male partner involvement in contraceptive uptake should be strengthened in the health facilities and the urban Somali refugee community using community strategy to improve male partner involvement. Religious leaders need to be engaged and IEC done to dispel myths and misconceptions.

## CHAPTER ONE: INTRODUCTION

### 1.1 Background Information

Women in developing countries are either under collective decision making with their partners or completely rely on the male partner's decision on issues that affect their reproductive health. Identifying the major factors influencing male partner involvement on contraceptive use has significant relevance for planning contextually appropriate family planning interventions. (UNFPA, 2010). In its Plan of Action, the 1994 International Conference on Population and Development (ICPD) acknowledged that men had been bypassed by Family Planning program and needed to be reintegrated into sharing jointly the responsibility for contraception: it recognized that, "appropriate methods for couples and individuals vary ... and ensure that women and men have information and access to the widest possible range of safe and effective Family Planning methods in order to enable them to exercise free and informed choice" (ICPD, 1994).

Male involvement in family planning (FP) means more than increasing the number of men using condoms and having vasectomies; male involvement also includes the number of men who encourage and support their partner and their peers to use FP and who influence the policy environment to be more conducive to developing male-related programs. In this context "male involvement" should be understood in a much broader sense than male contraception, and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family-planning practice (FHI, 2005).



According to UNHCR's most recent statistics, almost half of the world's 10.5 million refugees now reside in cities and towns, compared to one third who resides in camps (UNHCR, 2009). While UNHCR continues to strongly advocate for the freedom of movement for the refugees in Kenya, refugees are still required to live in designated camps as per the government of Kenya explicit encampment policy (UNHCR, 2009). The total refugee population in Kenya currently stands at 387,372, of which 272,712 (70.4%) live in Dadaab, 69,414 (17.9%) live in Kakuma and the remaining 45,246 (11.7%) live in Nairobi, with 300 to 500 new refugees arriving in Nairobi every week (UNHCR, 2010).

In the past, family-planning programs had focused attention primarily on women, because of the need to free women from excessive child-bearing, and to reduce maternal and infant mortality through the use of modern methods of contraception (FH1, 2009).

Provision of effective family planning care to populations affected by conflict and complex emergencies poses special challenges [UNHCR, 2010]. Health providers in the camps report that many refugees lack a basic understanding of healthy practices related to family planning and that traditional cultural practice and beliefs are barriers to accessing care and accepting FP services. This notion can be assumed to be the same for urban refugees because they originate from the same settings. Restoring access to safe, effective contraceptives can reduce unwanted pregnancies, unsafe abortion and resulting maternal death and disability. This will reduce the burden to the healthcare systems in terms of treating abortion related complications, and restore the quality of life to other children and members of the family because the mother is present (GIZ, 2009).

Involving men and obtaining their support and commitment to family planning is of crucial importance in the Africa region, given their elevated position in the African society. Most decisions that affect family life are made by men. The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision-making for family-planning matters, but would also accelerate the understanding and practice of family planning in general (UNFPA, 2008). Only recently have family-planning associations recognized the importance of men's role and motivation in fertility decision making, particularly in Africa.

## **1.2 Problem Statement**

Unintended pregnancy and birth, frequently due to contraceptive non-use or misuse, continue to be important public health problems in Kenya. (FHI, 2005) Population increase is a serious public health problem in Kenya. This problem is further compounded by an upsurge of refugees in the country owing to conflicts in their countries of origin. It is estimated that 500 new Somali migrants arrive in East Leigh each week illegally. (UNHCR, 2010) .The recent census in Kenya (KNBS, 2009) indicates that the refugee population in East Leigh has grown tremendously. Much of this growth has been attributed to natural increase and compounded by influx.

Decisions about contraceptive use and childbearing may be confounded by unequal power relations, especially in more patriarchal societies as in the Somali community which emphasizes on male dominance in the culture.

Male partner involvement in contraceptive uptake has been shown to greatly influence uptake and continuation rates. In a community where Results from the 2010 study of International office for migration in Kenya on urban Somali refugees in east Leigh showed that only 20% of refugees in urban setting are using family planning. Which is in contrast with the Kenyan women whose contraceptive prevalence rate is at 46% (KDHS, 2008/2009)it would be beneficial to find out if the men are involved and the factors influencing male partner involvement in contraceptive uptake. The reproductive health of urban refugees in Nairobi is an important issue for Kenya. Projections indicate that a large number of refugees migrating into towns will become permanent urban residents (UNHCR, 2009). Male partner involvements on contraceptive uptake amongst urban Somali refugees in East Leigh are not clear. This research therefore intended to investigate male partner involvement in contraceptive uptake amongst Somali refugees.

### **1.3 Research Questions**

1. What are the determinants of male partner involvement in contraceptive uptake amongst urban Somali refugees in East Leigh?
2. What is the male partner knowledge attitude and practices on contraceptive uptake amongst urban Somali refugees in East Leigh?
3. What are the strategies for increasing male partner involvement in contraceptive uptake amongst Somali refugees in East Leigh?

## **1.4 Objectives**

### **1.4.1 Broad Objectives**

The overall objective of this study was to investigate male partner involvement in contraceptive uptake amongst urban Somali refugees in Nairobi County Kenya.

### **1.4.2 Specific Objectives**

1. To determine male partner involvement in contraceptive uptake amongst urban Somali refugees in Eastleigh
2. To determine the male partner level of knowledge, attitudes and practices on contraceptive uptake amongst Somali refugees in Eastleigh.
3. To identify strategies for increasing male partner involvement in contraceptive uptake amongst Somali refugees in Eastleigh.

## **1.5 Hypothesis**

Male partner involvement in contraceptive uptake amongst Somali refugees in Eastleigh is not associated with any factors.

## **1.6 Justification and Significance of Study**

Effective use of contraceptive methods is facilitated when both husbands and wives have positive attitude towards contraception. The failure to involve men in Family Planning programs implies a failure to assess the potential acceptability of existing contraceptive methods (UNFPA 2009).

Currently, majority of urban refugees and asylum seekers in Nairobi originate from Somalia. According to United Nations High Commission for Refugees, the total fertility rate among the Somali population is between 5.7 and 6.7, irrespective of their geographical location as compared to the total fertility rate of the Kenyan woman at 3.9 births per woman, according to Kenya demographic and health survey of 2014. Decisions about contraceptive use and childbearing may be confounded by unequal power relations, especially in a patriarchal society as in the Somali community which emphasizes on male dominance in the culture. The Somali culture accords great value to the males as the sole decision makers.

Although the humanitarian crisis in Dadaab frequently makes headlines currently, the reality of daily life for refugees living in Nairobi is less documented. This study highlights the need for deepened commitment to the FP needs of Somali refugees living in Nairobi in order to ensure that practical challenges are adequately addressed (UNHCR 2011).

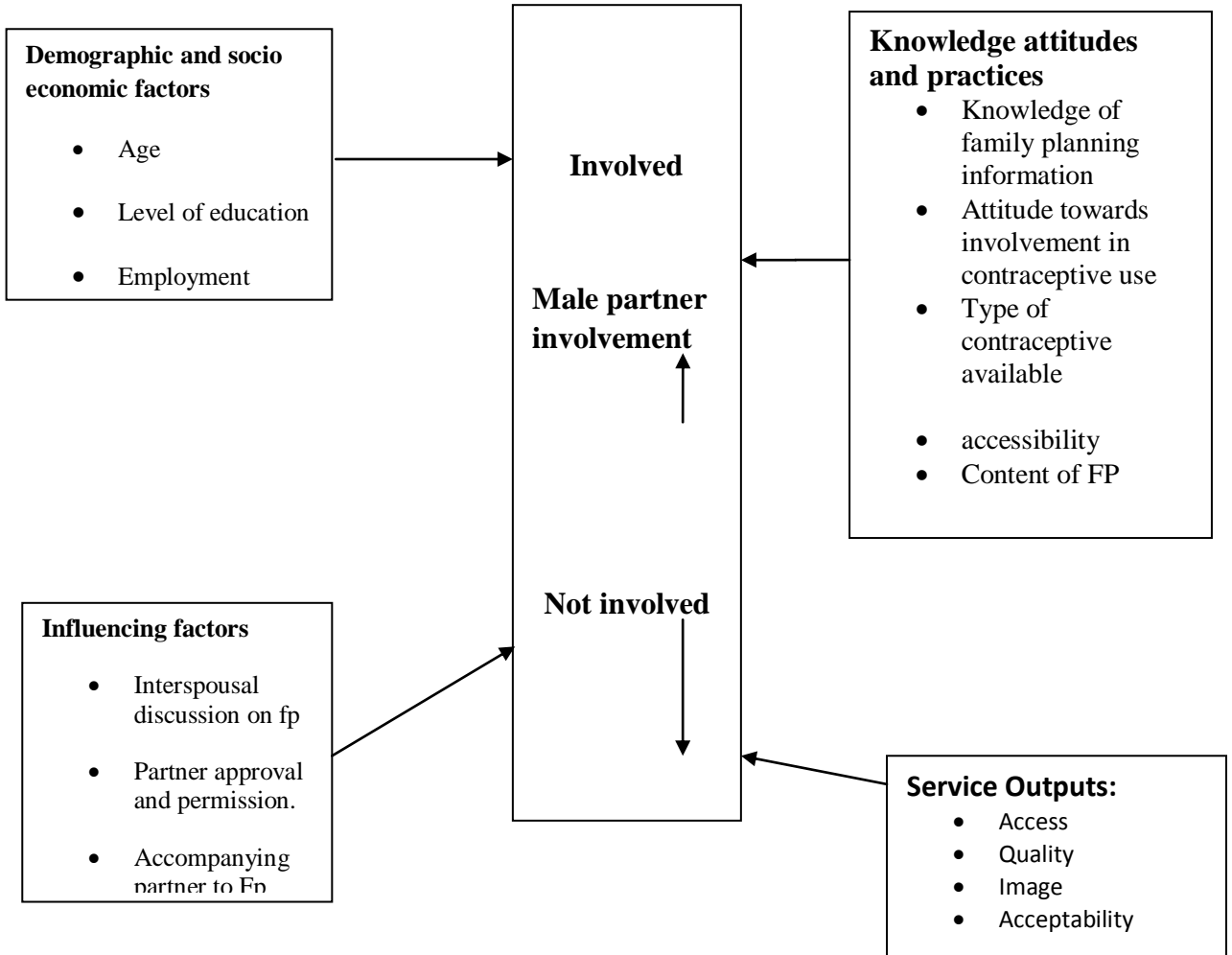
Male partner involvement in contraceptive uptake results into a reduction of burden to the health system infrastructure in terms of a reduction in the prevalence of complications and deaths related to Abortion and maternal death. Currently, few studies have been done to assess male partner involvement in contraceptive uptake amongst urban Somali refugees in Eastleigh, Nairobi County Kenya. The findings and recommendations from the study will be used to inform and develop strategies that would increase male partner involvement in contraceptive uptake amongst urban refugees.

### **1.7 Scope and Delimitations of Study**

The study took into account adult Somali male partners above 18 years of age, and currently living with a female partner. This was to ensure that partner participation was captured.

One of the anticipated limitations was inadequacy of reference data specific for the area.

However, references were made to studies made by IOM and other NGOs in the area.



**Figure 1.8: Conceptual Framework**

Source: Adapted from Literature review)

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Introduction**

Male partner involvement in contraceptive uptake generally signifies two distinct, yet-inter related, programmatic goals of encouraging the use of male contraceptive methods and expanding men's involvement in family planning decision-making process. (UNHCR 2011) The health of both men and women will improve, if men play a greater role in birth control. Male practice gives a balanced situation. Both from the perspective of birth prevention or reproductive health increased participation in family planning by males are, therefore, an essential step for augmenting the Contraceptive Prevalence Rate. (UNFPA 2012)

### **2.2 Urban Refugees**

Currently, the age old image of life in tented, sprawling camps no longer tells the full story of the refugees. As the world becomes more urban, refugees too are increasingly moving to urban areas which includes large towns and cities. Today, almost half of the world's 10.4 million refugees reside in urban areas, with only one-third in camps (UNHCR, 2011).

Today, urban refugees have been described as those who have self-settled in urban areas (UNHCR 2011). Urban Somali refugees refer to those persons originally from Somalia who have settled specifically in Nairobi due to the conflict and insecurity in their country.



Unlike the thousands of refugees living in Kenya's two refugee camps, refugees in urban areas are a largely hidden 'population: little is known about their numbers, profile, status, location and livelihoods. In Nairobi, refugees have been absorbed into the urban fabric, are dispersed over the city and are highly mobile (Sara et al, 2010).

Currently information regarding family planning in refugee situations show that interventions for refugee communities have primarily focused on increasing access through supply side improvements, as well as shifting behaviors and attitudes to enhance demand and use, however male involvement has limited

### **2.3 Importance of Male Participation in Family Planning**

There are a limited number of studies which have attempted to reveal the various aspects of the broad theme on 'Male participation in contraceptive uptake. Equity in gender relations and responsible sexual behavior highly stresses the need for men's active involvement in family planning. The interest in increasing active male participation in fertility regulation is two-fold, to balance reproductive health care more evenly between men and women and to increase the overall level of active users of fertility regulation.

The most important reason that emerges to promote male participation in family planning is that of fostering a better relationship between men and women through the practice of family planning as a joint and equal responsibility. It also provides women and girls the autonomy to determine the number and spacing of their children, access to

educational and livelihoods opportunities, and possibilities for families to manage scarce resources more effectively (UNFPA, 2010).

The Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings, developed by the Women's Refugee Commission on behalf of partners and endorsed by the steering committee of the Inter-agency Working Group (IAWG) on Reproductive Health in Crises in May 2010 outlines existing standards on providing contraceptives from the onset of an emergency and throughout protracted crisis and recovery. It further describes methods of service delivery and recommendations for governments, donors and implementing agencies. Fertility and future projected population growth are much higher in sub-Saharan Africa than in any other region of the world, and the decline in birth rates, which was already modest, has slowed even further over the past decade, which rests on the assumption that fertility will decline only if the population at large adopts effective modern methods of contraception and active involvement amongst all partners and service providers, as witnessed in other parts of the world. A woman's ability to space and limit her pregnancies has a direct impact on her health and wellbeing as well as the outcomes of each pregnancy (UNFPA, 2010).

While the United Nations High Commissioner for Refugees (UNHCR) has focused on emergency obstetric care, gender-based violence and HIV/AIDS in the past several years, family planning activities encouraging male partner involvement have not been given sufficient attention to ensure adequate access for refugees. Family planning

coverage in camp settings has reportedly been low; programs in the field are often very poor to non-existent. (UNHCR, 2010).

All individuals have the right to access, choice, and the benefits of scientific progress in the selection of family planning methods. A rights-based approach to the provision of contraceptives assumes a holistic view, which includes taking into account clients' sexual, and reproductive health care needs and considering all appropriate eligibility criteria and practice recommendations in helping clients choose and use a family planning method (GIZ, 2009).

Refugees in camps are accorded health services and family planning service provision as part of the UNHCR'S mandate and as an incentive by the host government to keep them concentrated in one area. By contrast, in non-camp settings assistance to refugees can be sparse, unevenly distributed, and insufficient to meet basic needs – if it exists at all. Health providers in city council health centers in Eastleigh report that many residents lack a basic understanding of healthy practices related to family planning and that traditional cultural practices and beliefs are barriers to accessing care and accepting family planning services. Although family planning services and clinical/counseling services are available through the GIZ health facilities, Private clinics and the city council of Nairobi health centers, the utilization of family planning methods is low at 20%.

#### **2.4 Global Trends of Male Partner Involvement in Contraceptive use**

Since the 1994 International Conference on Population and Development (ICPD), and the 1995 UN World Conference on Women, interest in men's involvement in reproductive health has increased. There has also been a shift in objectives of male participation and concerns, from increasing contraceptive use and achieving demographic goals to achieving gender equality and fulfilling various reproductive responsibilities (UNPD-WCU, 2011).

Many family planning Associations have now recognized that involving men and obtaining their support and commitments to Family Planning is of crucial importance in Africa because most decisions affecting family and political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level. Their involvement in family planning matters would therefore not only ease the responsibility borne by women in terms of decision making but would also accelerate the understanding and practice of family planning in general (IOM 2013).

The World Health Organization (WHO) estimated in 2012 that 287,000 maternal deaths occurred in 2010; sub-Saharan Africa (56%) and Southern Asia (29%) accounted for the global burden of maternal deaths. Men are also recognized to be responsible for the large proportion of ill reproductive health suffered by their female partners. It is well documented that men's general knowledge and attitude concern the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive methods used greatly influence women's preferences and opinions.

In Ethiopia, above 90% of male respondents have supported and approved using and choosing family planning methods, but none of them practiced terminal methods. Generally, more male respondents disagreed than agreed that men should make decisions about selected family planning issues in the family. Decision-making dynamics around method choice followed a slightly different pattern. According to female participants, decisions regarding method choice were equally made by women or jointly, with male-dominated decisions falling last.

Male involvement helps not only in accepting a contraceptive but also in its effective use and continuation. Spousal communication on contraception and reproductive goals suggests that the couple has an egalitarian relationship. Studies have shown that couples who discuss the number of children they desire or the use of family planning are more likely to use a contraceptive and achieve their reproductive goals than those who do not.

Contraceptive prevalence is lowest in Africa, where on average stands at 22.4%. However, regional disparities are pronounced. Average prevalence in Northern, Southern Africa is 44.8% and 58.1% respectively. In eastern, middle and western Africa are lowest observed among all regions of the world (UNPD-WCU, 2011). CPR stands at 22.9% in Eastern Africa, Middle Africa 6.6% Western Africa at 8.7%. In West Africa, only 13% of married women use some form of family planning, 23% indicate that they would like to avoid becoming pregnant in the near future, but are not using a family planning method resulting into an unmet need.

In the more developed area where the average level of use is 61.3%. Regional variations fall within a relatively range from 54.6% in Eastern Europe and southern Europe to 77.3% Northern Europe (UNPD-WCU, 2011). Globally female sterilization is most widely used method and alone for one third of all contraceptive use. The IUD is a distance second with 22% use world, followed by oral pill with 14% users, modern methods makeup a much a larger fraction of contraceptive use is the less developed regions (51.2%) than in the more regions 61 %.(UNPD-WCU,2011). A socio-economic hypothesis suggests that regions whose women have low education, limited formal-sector employment, and limited access to health and family planning outlets (supply factors) are expected to have low rates of contraceptive use.(WHO,2009). In addition, region of residence may be a proxy for ethnic or cultural boundaries that are related to acceptance of contraceptive methods (demand factors). Furthermore, the whole point about migration is that it changes the region of residence and mixes people; and many of the supply and demand factors are known for specific regions/provinces. (UNHCR, 2010).

### **2.5 Socioeconomic Factors Affecting Male Partner Involvement**

Socioeconomic factors such as education and improved living standards as well as social and cultural factors influence male partner involvement in contraceptive use. People have to be satisfied with the number of children they desire in order for them to use family planning services to stop having children. Somali refugees finding themselves in a different setting and having sometimes lost their children through the war or on the way to seek refuge in another country may not find family planning an

important issue. Therefore, although improvements in the provision of family planning services have generally helped in influencing the fertility change currently experienced in Kenya, other factors have also been involved. (KDHS, 2008-2009). Contraceptive use increases dramatically with increasing level of education. Sixty percent of married women with at least some secondary education use a contraceptive method compared with 40 percent of women with incomplete primary education and only 14 percent of those who never attended school.

Contraceptive prevalence peaks among married women in the 30-34 age-group and is lowest for women age 15-19. As expected, female sterilization is used more commonly by women age 40-49, while married women at the peak of childbearing age (20-39) are most likely to use injectable and pills. Use of male condoms is particularly high among sexually active unmarried women. (KDHS, 2008-2009).

## **2.6 Socio Cultural Factors Influencing Male Partner Involvement**

Marital status has been redefined differently to the categories used in the KDHS to capture contraceptive use. Many Married women who are not living with their partner may have a different contraceptive behavior from those who are married and living with their partner due to their circumstances of marriage and socio-cultural and economic expectations. Also, unmarried women and previously married may also differ in their contraceptive perception and use between them and among the other groups.

Contraceptive use is characterized by reliance on traditions mainly in the rural areas and modern methods in the urban areas. Migration may therefore lead to exposure to contraceptive for those who had not used any and to new methods for those who have been users. The Somali women refugees may just see the available modern contraceptives in the different country as they were unavailable in their country. Independent of changes in family size preferences, non-use may result in migrants' inability to obtain contraceptives in the new settings due to unawareness or inaccessibility of sources or from lack of sufficient resources to pay for the services in the new areas. Return migrants may devote less effort and resources to obtain contraceptives. (KDHS, 2008-2009).

The practice of family planning in Kenya increased steadily since the early 1980s with the contraceptive prevalence rate for all methods reaching 39% in 1998. Use of modern contraceptives rose from 4% to 32% among married women between 1978 and 1998. At the same time Kenya witnessed a historic decline in fertility, the total fertility rate decreasing from 8.1 births per woman to 4.7 births per woman in 1998. Indeed, Kenya's Family Planning Programme has been an unprecedented success story in sub-Saharan Africa.

The increase in contraceptive prevalence rate is an indication of the efforts made by women to implement their fertility desires. This suggests that as the facilities for family planning services increased, more women who said that they did not want any more children started using contraceptives, and therefore fertility declined. (KDHS, 2008-2009).



In a study by I.O.M 2011, urban Somali refugees interviewed, reported never having used contraception is 63%, 23% reported currently using while 11% reported using previously. During debriefing sessions the interviewer reported that participants would often look around to make sure no one was listening, before responding that they have used contraception. This suggested that there is stigmatization towards the use of contraceptive in this Somali refugee community which is confirmed by the research findings. 24 percent claim that their culture does not allow it while 16 percent cite fear of adverse effects. 14 percent claim that their husbands does not allow it another 14% claimed that they did not think they needed to, 6% did not know what contraception and 2% are afraid of authorities, thus the belief in not using contraception for cultural or religious reasons seems quite prevalent in this community which is a challenge for health promotion activities. Refugee women should be involved in all aspects of family planning programs; and the programs should be conducted with full respect for the various religious and ethical values and cultural backgrounds within the refugee community (IOM 2011).

### **2.7 Knowledge, Attitude and Practices of Contraceptive Methods**

Development of a profile regarding knowledge of family planning as it's a prerequisite for making a decision to initiate contraceptive use. Education level shows whether the likelihood of contraceptive use is high among educated people or not and helps in inference to the attitudes and perceptions to fertility regulation and desired family size, especially among partners. (KDHS, 2008-2009).

Male involvement in family planning is more than just increasing the number of males using condoms and having vasectomies. It includes narrowing the scientific evidence gap on the number of men who encourage their partners and their peers to use family planning and who influence the policy environment to support the development of male related family planning programs (UNFPA 2012). Modern methods are more familiar to women than traditional methods; 95 percent of women know at least one modern method, and only 69 percent know a traditional method. Among women, the most widely known modern methods of contraception are male condoms, injectables, and pills, with about 89 percent of all women saying they know of these methods.

Religious affiliation is a major cultural factor affecting the use of FP methods. Religion and culture play a pivotal role in Somalis' views and decisions about family planning. Adherents of religions that favor large family size are characterized by lower use of contraception. Children are a gift from Allah, and the number of children one has is according to his will, culturally, large families are desired and give status to parents. Virtually 100% of Somalis are Muslim, though they practice in varying degrees. Since a great majority of Somalis are Muslim, cultural norms and religious norms are often indistinguishable. Some believe modern methods are allowed by analogy, e.g., the Prophet Muhammad used what was available to him in his time, so Muslims now can use what is available to them. Others believe that barrier methods are acceptable (condom, diaphragm) but hormonal methods are not because they interfere with a woman's natural state/system. Sterilization (tubal ligation, vasectomy) is widely

considered unacceptable in Islam because it does “permanent harm” to a person (JRS, 2009).

In a study by IOM 2011, amongst Somali women refugees in Eastleigh, In terms of type of contraception, the use of injectable was reported by 12% of participants while 16% report using oral contraceptives (pill) 11% report using Implants. Of note, all are female methods of contraception’s for example none of the participants reported using a male condom. For those who used contraceptive then stopped there were only two reasons cited they wanted to have a child, fear of adverse effect 3%.the second reason suggest that this community may benefit from education around adverse effects. It may also be interesting out what information brought out this fear and led to behavior change and how this information was disseminated.

## **2.8 Source of Contraception and Informed Choice**

Information on where women obtain their contraceptives is useful for family planning program managers and implementers for logistic planning. In the 2008-09 KDHS, women who reported using a modern contraceptive method at the time of the survey were asked where they obtained the method the last time they acquired it. Current users of modern methods who are informed of potential side effects and problems of each method are best able to make an informed choice about the method they would like to use. (KDHS, 2008-2009).

Current users of various modern contraceptive methods, who started the last episode of use within the five years preceding the survey, were asked whether, at the time they were adopting the particular method, they were informed of possible side effects or problems and what to do if they experienced them. The indirect association may be through the effects of the different family formation variables, which have a direct association with the use of contraception. In addition, the socio-economic, cultural and demographic fertility related factors might encourage the use of contraception, either directly or through migration status categories. Furthermore, migration per se may also have a direct effect on contraceptive behavior. For instance, migrants may find themselves unable to continue with contraceptive use either because of lack of knowledge of where to get contraceptives in the new environment. Use of contraceptive methods may also not be advisable if the woman is involved in migration because of their associated inaccessibility and side effects.

### **2.9 Contraceptive Methods that may be provided in Refugee non Camp Settings**

Providers and users must be aware of the particularities of each method, its effectiveness, safety, side effects. They should also know its effect on the risk of STD transmission, its appropriateness for breastfeeding women and the usual length of time between discontinuation of the method and return to normal fertility (JRS, 2010). Family planning allows individuals and couples to anticipate and attain their desired number of children and the timing and spacing of their births. It is achieved through the use of contraceptive methods (UNFPA, 2009). A woman's ability to space and limit

her pregnancy has a direct impact on her health and wellbeing as well as outcome of each pregnancy (IOM, 2015).

### **2.9.1 Barrier Method**

In most refugee situations, the most important barrier method will be male latex condoms. Consistent and correct use of condoms can play the dual role of protection against STD and HIV infection and prevention of conception. They can be used alone or in combination with another method to increase effectiveness. Only water-based lubricants should be used with condoms

Other barrier methods, such as spermicidal and female condoms, may be requested by refugees who are familiar with these methods from their country of origin. If requested, every effort should be made to supply these methods.

### **2.9.2 Hormonal Contraceptives**

Oral Contraceptive Pills should include at least: Injectable Contraceptives could include depot-medroxyprogesterone acetate (DMPA, Depo-provera), one injection every three months, Norethisterone Enanthem (NET-EN) one injection every 2 months, or Cyclofem, one injection per month. Trained health professionals should administer injectables. It is recommended that only one injectable method should be used to avoid confusion and misunderstanding over the schedule for reinjection. Supportive counselling and continued reassurance during follow-up visits will help clients tolerate common side effects, like changed patterns of menstrual bleeding.

### **2.9.3 Copper IUDs (Intra-Uterine Devices)**

IUD insertion, like sterilization and implants, requires special training, facilities and equipment that must be in place before these methods are provided. Women known to be infected or at high risk for an STD, including HIV, should not have an IUD inserted. For nulliparous women, an IUD is not the method of first choice.

### **2.9.4 Hormonal Implants**

An implant is a long-lasting progestogen-only contraceptive. The most widely used types (Norplant and Norplant 2) consist, respectively, of six or two silastic capsules containing the progestogen levonorgestrel. The capsules, inserted under the skin of the arm, slowly release the progestogen. These implants are effective for five years. They should only be inserted or removed by properly trained personnel. Before using any long-term contraceptive within a refugee situation, service providers must be sure that the necessary facilities and skilled personnel exist in the country of origin to reverse or remove the method, since refugees may return home at any time. If such facilities do not exist in the country of origin, the method should not be used.

### **2.9.5 Voluntary Surgical Contraception**

Both male (vasectomy) and female sterilization are desirable methods of contraception for some clients. As a surgical method, sterilization should only be performed in safe conditions, with the formal consent of the user and by trained personnel with the necessary equipment.

### **2.9.6 Natural Family Planning (NFP) Methods**

Natural Family Planning methods include the basal body temperature method, the cervical mucus or ovulation method, the calendar method and the sympto-thermal method. NFP is particularly appropriate for people who do not wish to use other methods for medical reasons or because of religious or personal beliefs. Counseling must be provided to both partners when choosing these methods and when practicing them. The methods require initial training and regular follow-up until confidence is achieved in detecting fertility signs. Teaching these methods to potential users is relatively time consuming, and requires separate sessions for those refugees who wish to use them.

### **2.9.7 Breastfeeding**

Breastfeeding is effective as a contraceptive method if a woman is exclusively breastfeeding on demand her infant (no other food being given to the baby), she is not menstruating and her infant is less than six months old. If any one of these three criteria are not met, then an additional method of contraception is advised. Family planning methods recommended for breastfeeding mothers are: from delivery up to six weeks postpartum: barrier methods, postpartum IUD insertion and sterilization; from six weeks to six months postpartum: barrier methods, progestin-only methods (pills, injectables, implants), IUDs, and sterilization after six months postpartum: COCs and combined injectables, and natural family planning methods.

## **2.10 Factors Influencing Male Partner Involvement in Contraceptive Uptake**

### **2.10.1 Access to Family Planning Services**

Accessibility is a multi-dimensional, concept that not includes physical proximity and travel time to services, but also involves economic physiological and attitudinal costs cognition and perceptions of potential clients (Dang and Nguyen, 2002). In a patriarchal society like Somali refugee community, men as the husband in a couple's life have an important say in decision-making about family size and use of contraceptives. As the FP service delivery system is largely female-oriented, there are very limited opportunities for men to receive FP information from service providers, and hence because they cannot receive FP information they cannot make proper judgments regarding the same. The challenges facing sub-Saharan Africa as it strives to meet, or even closely approach, its development objectives are more daunting than those facing any other region in the world. These objectives include the goals and targets for 2015 set at the ICPD in 1994 and the ICPD+5 follow pin 1999, and by the United Nations Millennium Summit in 2000. The region will continue to need the highest per capita levels of technical and financial support of any region, along with renewed and sustained political commitment, if it is to make major progress towards reaching those goals by 2015.

### **2.10.2 Myth and Misconceptions**

There are barriers to community access to FP; these include myths and various misconceptions related to specific methods of family planning. Traditional beliefs still



impact negatively on RH thus limiting community male involvement access to reproductive health.

There are cultural beliefs and practices that may hinder male partner involvement in contraceptive uptake, for instance preference for sons among some communities in sub-Saharan Africa (WHO, 2008).

### **2.10.3 Lack of Capacity Building and Training**

The training carried out for medical officers in RH services is lacking on aspects of gender, contraceptive technology updates, ASRH, HIV/AIDS, Community RH, RH research, etc. These aspects are considered pivotal in the effective provision of FP services at the community level including CHWs and CHEWs to provide RH services at camp settings. There is need for additional training, staff time and cost to ensure access to RH services by the all. Many policies do not access friendly services in camp setting and for refuges. Standardization is important, both for the approach to training and the materials used, and it can be achieved by assembling a training team that brings master trainers and district and NGO trainers together.

### **2.10.4 Dissatisfaction with Male Contraceptive Choices**

Timely care seeking on issues of RH and by extension community FP is still low. Levels of empowerment at the community level and refugee settings are still low thus unable to facilitate the creation of enabling environment that leads to behavior change. There is need to enhance community linkages and support systems for effective provision of FP services through supervision (UNHCR, 2009).

### **2.10.5 Gender Biases and Poor Attitude**

Gender biases within the family set up still has a lot of bearing on the ability of the community to access FP services. In some instances the males are domineering. While in some Male involvement is still low yet they are the decision makers in camp setting and refugees. RH service providers' attitude either endears the community to continue seeking FP services or puts them off. This is seen in the when many women request involving men in reproductive health is central to the achievement of rights within and beyond the health sector. It is obvious that woman-centered MDG goals 3 (promoting gender equality and empowering women) and 4 and 5 (improved child and maternal health) are mutually reinforcing. Indeed, they cannot be attained independently of one otherness TBAs to assist them even during delivery because they are caring enough.

### **2.10.6 Facility Factors**

There is lack of appropriate logistic facilities (i.e., clinic, methods, supply and follow-up) for male participation in family planning. Men lack full access to both information and services because their contraceptive needs are neglected by providers. They cannot make informed decisions nor take active part in family planning. No separate clinics/health and family planning service centers for men exist in Eastleigh to counsel men on their reproductive responsibilities and use of contraceptive methods.

Inadequacy of logistic facilities for males is reflected in the functional health and family planning (FP) centers both in the public and private sector, the family planning services that are provided there are mainly female centered. Separate arrangements for men are non-existent, so they cannot feel their privacy and presence secured.

**2.10.7 Inter-spousal Discussion about Family Planning**

Lack of desired communication between spouses about family planning may also be a serious factor influencing male partner involvement to contraceptive use.

## **CHAPTER THREE: MATERIALS AND METHODS**

### **1.0 Introduction**

This chapter explains the research methodology; the research design, development of research instruments, data collection, analysis and reporting.

### **3.1 Research Design**

Research design is the plan and structure of conducting a study (Kothari, 2004). The study was descriptive cross-sectional in nature and adopted both quantitative and qualitative methods. Qualitative perspectives deal with contextual issues pertaining to what happens on the ground which can only be obtained through in-depth interviews, focus group discussions and non-directive interviews like open-ended questionnaires (Kothari, 2004).

According to Mugenda and Mugenda (2003) descriptive research is used to obtain information concerning the current status of the phenomena to describe what exists with respect to variables or conditions in a situation. The researcher considered this design as appropriate since it facilitated gathering of reliable and accurate data that clearly described male partner involvement in contraceptive uptake amongst urban and Eastleigh areas of Nairobi

## **3.2 Study Variables**

### **3.2.1 Independent Variables**

The independent variables were demographic and socio economic characteristics. Knowledge attitude and practice of men towards male involvement in contraceptive uptake.

### **3.2.2 Dependent Variables**

The dependent variable was male partner involvement in contraceptive uptake amongst urban Somali refugees in East Leigh. Which was measured based on the summative score of questions designed to assess male involvement in contraceptive uptake, male partners with a score of three and above were considered to be involved in contraceptive uptake ,they included spousal communication, accompanying partner to FP clinic, willingness to use male methods of contraceptives and giving permission for contraceptive use. These questions were used to construct Scores and were summed and dichotomized (*not involved* =0-2, *involved*=3-4).

## **3.3 Location of the Study**

The study took place in East Leigh section II of Nairobi. UNHCR estimates that the number of registered non-camp refugees and asylum seekers in Nairobi of Somali origin to be 23,000. However the number of unregistered refugees is considered to be much higher. The total population of Eastleigh is estimated to be approximately 300,000-500,000 (KNBS, 2009). Eastleigh is a bustling suburb of Nairobi town situated on the eastern side of Nairobi with a large Somali population. It is also known as Mogadishu

ndogo (small Mogadishu) because of the large number of Somali nationals who have exceeded the host population in that particular area. Other migrants of Eastleigh are of Ethiopia, Eritria, Sudanese and other origins.

### **3.4 Target Population**

According to Mugenda and Mugenda (2003), target population is that population which a researcher wants to generalize the results of the study.

The target population was adult male partner Somali refugees above 18 years of age from an estimated registered population of 23000 people living in a non-camp setting of Eastleigh Nairobi Kenya (UNHCR, 2011).

### **3.5 Selection Criteria**

#### **3.5.1 Inclusion Criteria**

The study included adult male Somali refugees above 18years having a female partner who consented to participate in the study and who had stayed in Eastleigh for at least three months. This was necessary because the refugees should have had some time to interact with host community and be familiar with the existing reproductive health options available in the area.

#### **3.5.2 Exclusion Criteria**

The study excluded male Somali refugee who were too sick to participate and those who were mentally ill

### 3.6 Sample Size Determination

Sampling is a procedure used to select a representative part from a population of study.

(Mugenda and Mugenda, 2003)

The desired sample was obtained using the Fischer formula (Kothari, 2004),

$$n = \frac{pqZ^2}{d^2}$$

n=the desired sample size

z=the standard normal deviate which is 1.96 at 95% confidence level.

p=Percentage of uptake of FP among women refugees (20% in this study).

q=1-p (1-0.20) =0.80

d=the level of statistical significance set.

z=1.96

p= 0.2

q= 0.8

d=0.05x 0.05

n=3.84x0.20x0.80

0.0025

= n=249.76

Sample size will be 250.

### Sampling Techniques

Sampling is a procedure used to select a representative part from a population of study.

(Mugenda and Mugenda, 2003).

The study participants were sampled into the study using purposive sampling technique.

East Leigh section 3 was purposively selected because it is the residential hub for Somali refugees. Research assistants were trained over 3 days, including 1 day for piloting and adjustment of the questionnaires.

Simple random sampling was used in selecting the respondents so as to ensure that the entire refugee men who met the inclusion criteria in the sampling frame had a chance of being selected.

Since the study was dealing with a hard to reach population due to the government directive in December 2012 for all urban refugees to relocate to Kakuma and Dadaab camps, the researcher focused on the UNHCR database of registered urban refugees in east Leigh.

To select the 250 respondents, every registered refugee in the database who had a female partner was enumerated by giving a number ranging from 1 to 500. These numbers were put in a basket and the 250 respondents were picked randomly. The numbers picked were corresponded with the refugees in the sampling frame to make the target sample of 250 respondents.

This method ensured that all the refugees who qualified had a chance of being selected

The key informants were also purposively identified from agencies working with refugee and the refugee community leaders as the persons who are knowledgeable in refugee issues

### **3.7 Research Instruments**

A combination of data collection tools was used to gather the information in the study.

They included:



### **3.7.1 Questionnaires**

These were the main instrument for quantitative data capture among the study subjects. The 250 questionnaires were administered by trained Somali research assistants to all Somali male partner refugees who consented to participate in the study and meet the inclusion criteria. Owing to the security situation in Eastleigh, the research assistants were recruited from amongst the refugees in East Leigh and they were people who were well known and had conducted other studies in the area. This was done to ensure that non-resident research assistants are not put in danger or arouse suspicion and hence compromise the quality of data collected.

The questionnaires were designed to assess individual demographic, socio-economic and facility factors which influenced male partner involvement in contraceptive uptake.

### **3.7.2 Focused Group Discussions**

The FGDs were intended to gather qualitative data and assess the knowledge, beliefs, attitudes and practice in relation to male partner involvement in contraceptive uptake. They were conducted at the Mariestope's clinic in Eastleigh which is a safe place with ample security and also ensure quality of data collected. It targeted refugee leaders and health workers.

### **3.7.3 Key Informant Interview Guide**

Clinical officer and family planning nurses were interviewed using the Key informant guide to establish the level of male partner involvement in contraceptive uptake at the

facility level. This was to help in pointing out factors influencing male partner involvement in contraceptive uptake at the health facilities.

### **3.8 Pretest**

The research instruments were pre-tested at East Leigh section III. It was done to ensure the validity and reliability of the data collection tools. The exercise was used to make corrections, clarifications, suggestions and highlight omissions to improve the research instruments.

### **3.9 Validity and Reliability**

A pilot study was done to ensure true and accurate answers. It was ensured through well designed questionnaires and selection, training and supervision of research assistants.

Daily checks and corrections of completed questionnaires was also done. Data checking and cleaning was done simultaneously during data collection. At the end of every field day, data was checked for completeness and consistency.

### **3.10 Data Collection Techniques**

Data collection was carried out using interviewer administered semi-structured questionnaires by the researcher and trained research assistants. The questionnaire was used to collect data from the Somali men. The FGDs at the community were conducted using an FGD guide. Key informants at the health facility were interviewed using key informant interview guide.

### **3.11 Data Analysis and Presentation**

Data analysis is a process of bringing order, structure and meaning to the mass of information collected (Mugenda and Mugenda, 2003).

Data presentation and analysis was collected and presented using tables and descriptive analysis. Quantitative data from the field questionnaires was double entered into a computer database designed using MS-Access application. Data cleaning and validation was performed in order to achieve a clean dataset that was exported into a Statistical Package format (IBM SPSS) ready for analysis.

#### **Data Analysis**

Data analysis was conducted using SPSS version 24.0 statistical software. Exploratory data techniques was employed at the initial stage of analysis to uncover the structure of data and identify outliers or unusual entered values. Descriptive statistics such as proportions were used to summarize categorical variables.

***Bivariate analysis:*** Pearson's Chi-square test and Fisher exact test were used to determine factors associated with the dependent variable (*male partner involvement in contraceptive uptake*). All independent variables were singularly associated with the dependent variable to determine which ones had significant association. Odds Ratio (OR) and 95% Confidence Interval (CI) were used to estimate the strength of association between independent variables and the dependent variable.

***Multivariate analysis:*** All independent variables identified to significantly associate with *male partner involvement in contraceptive uptake* at bivariate analysis were considered together in a Multivariate analysis. The analysis was performed using Binary logistic regression where backward conditional method was used in order to identify confounders and/or effect modifiers.

Adjusted odds Ratios (AOR) and 95% Confidence Interval (CI) were used to estimate the strength of association between the retained independent variables (factors) and *male partner involvement in contraceptive uptake*. The threshold for statistical significance was set at  $p < 0.05$ .

### **3.12 Logistical and Ethical Considerations**

Permission to carry out study was sought from Kenyatta University – Ethics Review Committee (KUERC) (Appendix VII), National Council for Science and Technology (NCST) (Appendix VI) Informed consent was obtained from the study participants. Confidentiality and anonymity was maintained by not using names of the study participants or any form of identification in the research instruments.

## **CHAPTER FOUR: RESULTS, DATA ANALYSIS AND INTERPRETATION**

### **4.1 Introduction**

This chapter contains detailed findings and presentation of collected data on male involvement in contraceptive uptake from the sampled study participants. The results are presented in form of tables, graphs and charts. The findings are presented based on the study objectives. The main objective of the study was to investigate male partner involvement in contraceptive uptake amongst urban Somali refugees in East Leigh, Nairobi County Kenya. Including male partner level of knowledge, attitudes and practices on contraceptive uptake amongst Somali refugees in East Leigh.

#### **4.1.1 Actual Sample Size**

The interview schedules were administered by the researcher, assisted by a researcher assistant directly to the respondents through conducting interview. The study targeted 255 urban Somali refugee men who were currently living with a female partner, 2 focus group discussions and 3 key informants. During data collection, 2 focus group discussions was conducted, 255 urban Somali refugee men and 3 key informants respondents were interviewed, contributing to 100% response rate for group discussions and all respondents.

The response rates was representative and conforms to Mugenda and Mugenda (2003) stipulation that a response rate of 50% is adequate for analysis and reporting ;a 60% is good and 70% and over is excellent. In order to achieve the maximum response rate, assuring the respondents of confidentiality, the researcher focusing on the UNHCR

database of registered urban refugees in east Leigh, since the study was dealing with hard to reach population due to the Kenyan government explicit encampment policy using research assistants of Somali origin and explaining the significance of the study to the respondents was done to maximize the response rate. The questionnaires were administered, filled anonymously, and collected immediately to ensure maximum return rate.

#### **4.2 Demographic and Socio Economic Characteristics of the Respondents**

A total of 250 male partners were interviewed during the study. The summary of socio-demographic and economic characteristics of the respondents is shown on Table 4.1

The highest percentages of the respondents were aged 30 - 39 years (30.0%) and 40 - 49 years (29.2%), with the highest percentage (44.8%) attaining college as the highest level of education. About half (52.4%) of the respondents indicated to have stayed in Eastleigh as a refugee for 5 - 10 years. More than half (58.0%) of the respondents were self-employed while 7.2% were unemployed. Regarding the average monthly income, 39.2% were earning 20001-30000 Kenyan shilling followed by 30001-40000 Kenyan shilling (26.8%) while only (10.4%) had above 40000 Kenyan shilling. About (56.0%) of the respondents started living with a woman when they were 18 - 22 years.

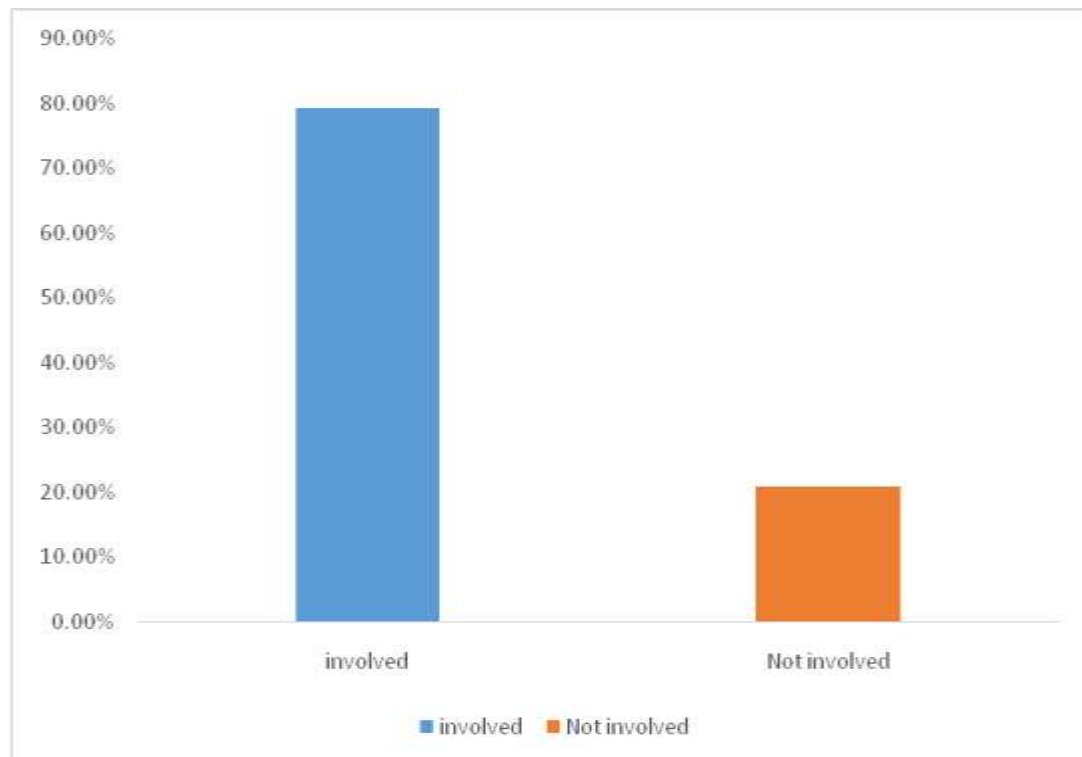
**Table 4.1. Socio Demographic and Economic Distribution**

Percentage distribution of respondents by selected background characteristics

<b>Variables</b>	<b>Frequency (n=250)</b>	<b>Percent (%)</b>
<b>Age in years</b>		
<30 years	59	23.6
30 - 39 years	75	30
40 - 49 years	73	29.2
50 years and above	43	17.2
<b>Level of education</b>		
None	38	15.2
Primary	43	17.2
Secondary	57	22.8
College	112	44.8
<b>Duration of living in Eastleigh as a refugee</b>		
<5 years	40	16
5 - 10 years	131	52.4
>10 years	79	31.6
<b>Current employment status</b>		
Salaried Job	17	6.8
Self Employed	145	58
Casual labor	70	28
Unemployed	18	7.2
<b>Average monthly income</b>		
5001-10000	38	15.2
10001-20000	21	8.4
20001-30000	98	39.2
30001-40000	67	26.8
Above 40000	26	10.4
<b>Age when first started living with a woman</b>		
< 18 years	15	6
18 - 22 years	140	56
23 - 27 years	95	38

### 4.3 Male Partner Involvement in Contraceptive

According to the study, 79.2% of the male partners interviewed were involved in contraceptive uptake with their partners. However, 20.8% were not involved. This showed that the urban Somali refugee men level of involvement in contraceptive uptake was above average as the majority of the respondents scored above two points out of the three maximum points (75%) from the three components the study used to classify a participant as involved in contraceptive uptake. The three components included interspousal communication, accompanying partner to Fp clinic and partner approval and permission with regards to contraceptive uptake.



**Figure 4.1: Male Partner Involvement in Contraceptive uptake**



### **4.3.1 Inter-spousal Discussion about Contraceptive Uptake**

Inter-spousal discussion is essential for male involvement in contraceptive uptake. The participants in this study were involved in discussions regarding contraceptive use or non-use. More than half (62.8%) of the male partners discussed on such issues as when to achieve pregnancy, and/or prevent pregnancy and the use of contraceptives. Male involvement with regards to interspousal discussion on contraceptive emerged as an area where Somali male partner refugees were doing better.

### **4.3.2 Partner Approval before Contraceptive Use**

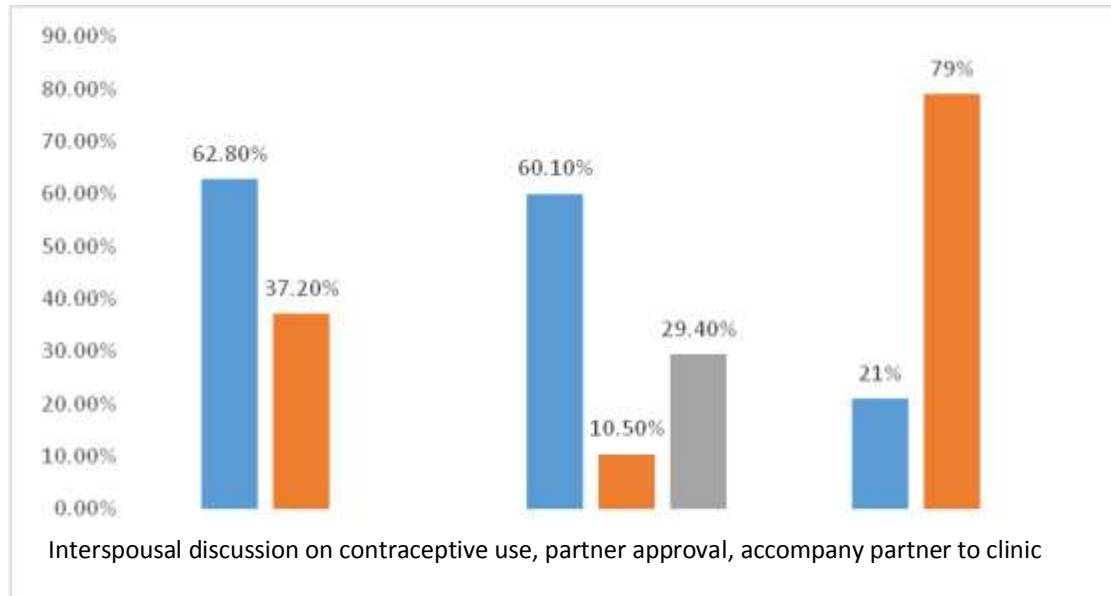
Partner's approval and permission before contraceptive use is important in male partner involvement in contraceptive uptake. (Kabagenyi, 2014).

According to the study findings, 44.7% of men supported use of FP methods of their partners/wives. Almost three fifth (60.1%) of the respondents were neutral to approve use of contraceptives and 10.5% did not approve use of contraceptive while 29.4% approved it. The reasons mentioned for the disapproval were the desire to have more children, fear of side effects, religious prohibition, and the thinking that it is only the issue of women. Partner permission was above average since majority of the respondents responded that they were neutral to and approved their female partners' use of contraceptives.

### **4.3.3 Accompanying Partner to the FP Clinic**

It has been shown that partners who are accompanied to the Fp clinic have higher continuation and success rates. According to the study findings, only 21% of the

respondents interviewed accompanied their partners to get contraceptives from any facility where the spouses were receiving contraceptives. Male partners did poorly with regards to the level of involvement measured by accompanying the spouse to receive Fp



**Figure 4.2: Partner Approval before Contraceptive use, Accompanying Partner to the fp Clinic, and Interspousal Discussion on Contraceptive use**

#### **4.4 Knowledge Attitude and Practice of Male Partners on Contraceptives**

This section had investigations on how the level of knowledge, attitudes and practices influences male partners' involvement on contraceptive uptake.

##### **4.4.1 Level of Knowledge on the Available Contraceptives**

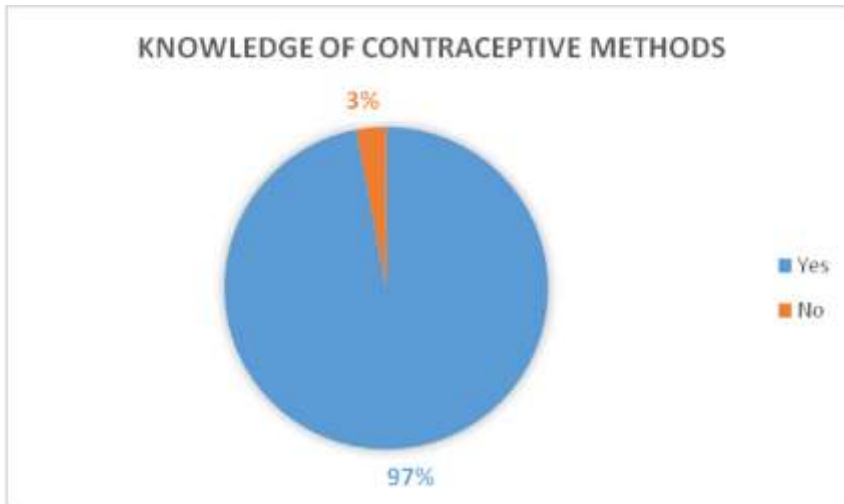
Development of a profile regarding knowledge of contraceptive methods was one of the major objectives of the study, because knowledge of contraceptive methods is a prerequisite for making a decision to be involved in contraceptive use. Information on knowledge of contraception was collected during the study by asking respondents to

name ways or methods by which a couple could delay or avoid pregnancy. If the respondent failed to mention a particular method spontaneously, the interviewer described the method and asked if the respondent recognized it. In this manner, information was collected about methods of family planning that included, the pill, intra-uterine device (IUD), injectable, implants, female condoms, male condoms, lactational amenorrhea, and two traditional methods (rhythm and withdrawal). Provision was also made within the questionnaire to record any other methods named spontaneously by the respondents. Almost all participants indicated that they had heard about family planning services and were able, in general terms, to explain their understanding of the concept of family planning and its main purposes.

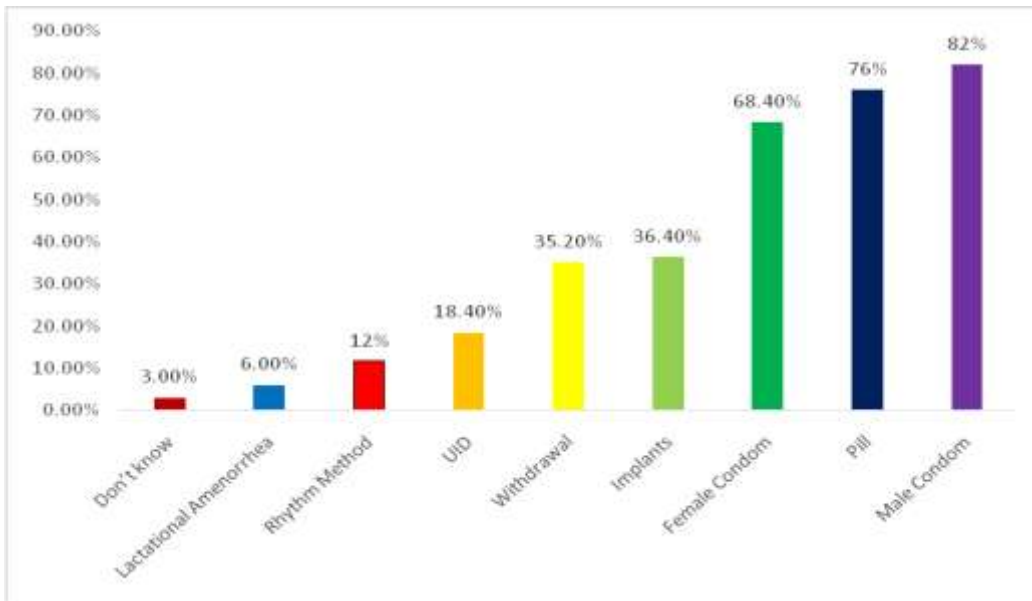
The overall level of knowledge amongst the respondents was excellent. Male partners were asked if they knew the available methods of contraception and 97% responded yes whilst 3% did not know of any methods used to delay pregnancy. The respondents were further asked to mention the contraceptive methods they knew, of those mentioned, most respondents 82% knew the male condoms followed by 76% knew pills, 68.4% knew female condoms. Those who knew about implants and withdrawal were 35.2% respectively.

On the other hand male partners asked if they knew the importance and benefits of male involvement in contraceptive use, the overall knowledge was score was good since 98.2% scored above two points out of the possible three points from the questions used to determine importance of contraceptive use and male involvement as shown in table

4.2. Knowledge on other contraceptive methods such as IUD, female sterilization, rhythm method, and lactational amenorrhoea, were 18.4%, 12.4%, 11.6% and 6.4% respectively as shown in table 4.3.1 below.



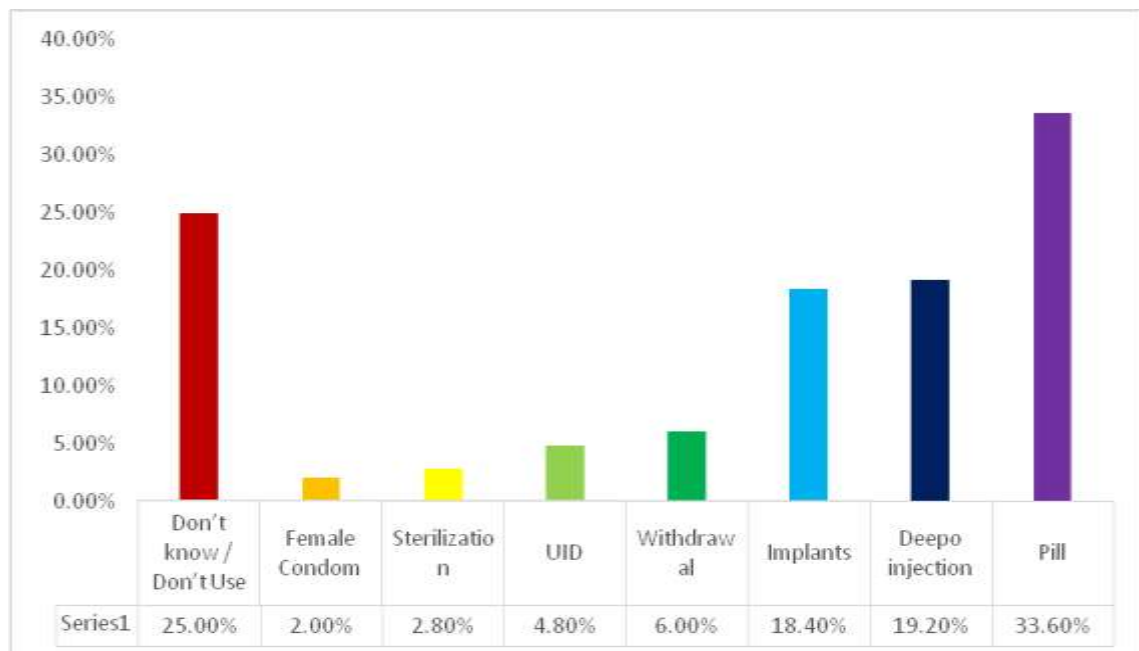
**Figure 4.3: Level of Knowledge on the Available Contraceptives**



**Figure 4.4: Mentioned Methods that could be used to delay Pregnancy**

The respondents were asked if their spouses were currently using any method .About three quarter (76.4%) of the respondents mentioned that their spouses were currently using some type of contraceptives.

Figure 4.5 presents the contraceptives used by spouses. Most commonly mentioned included; pills (33.6%), deepo injection(19.2%) and implants (18.4%). However, female condom was the least method (2.4%) used by spouses.



**Figure 4.5: Contraceptive methods used by Partner**

About half of the respondents 53.6% indicated that decisions about health care were made jointly with the partner. However, the highest percentage 42.4% disagreed that male partners are actively involved in decision making for contraceptive use in the community. More than half 55.6% agreed that women are discouraged by their partners from using contraceptives in the community.

<b>Table 4.2: Knowledge on Importance and Benefits of Contraceptives</b>		
<b>Percentage distribution of respondents knowledge and importance of contraceptive use</b>		
<b>Variables</b>	<b>Frequency (N=250)</b>	<b>Percent (%)</b>
<b>Do you know the importance of contraceptives</b>		
Yes	98	39.2
No	152	60.8
<b>Importance of contraceptives and benefits and male involvement( Grades)</b>		
Good (75% and above)	225	90.2
Poor (below 50%)	25	9.8
<b>Families that use contraceptives live better lives because they can plan families based on their resources</b>		
Agree	237	95
Disagree	13	5
<b>male partner involvement will ensure successful uptake and continuation rates</b>		
agree	31	12.4
disagree	219	87.6
<b>Contraceptive use promotes reduced maternal and child mortality rates</b>		
Agree	225	90
Disagree	25	10

#### **4.4.2 Attitude towards Male Involvement in Contraceptive Uptake**

The attitudes of male partners were assessed on a Likert scale whether they had interest in male partner involvement in contraceptive uptake; accordingly, 39.2% of the respondents had interest to know more about male involvement but 60.8% of the respondents had no interest to do so. Male partners attitudes about their roles in contraceptive uptake decision-making were assessed on a two-tier scale of agree and disagree. Accordingly, most male respondents 72.4% disagreed that men and women

should make decisions jointly about contraceptive uptake in the family; 87.6% disagreed that male partner involvement will ensure successful uptake and continuation rates; 72.8% disagreed that male partners should share the responsibility of contraceptive uptake and use. According to the study findings, the male partners had a negative attitude towards involvement in contraceptive uptake based on the statements assessing attitude.

**Table 4.3: Attitude towards Male Involvement in Contraceptive Uptake**  
**Percentage distribution of respondents who agree or disagreed to statements assessing attitude**

<b>Variables</b>	<b>Frequency (N=250)</b>	<b>Percent (%)</b>
<b>Interested to know more about male involvement in contraceptive uptake?</b>		
Yes	98	39.2
No	152	60.8
<b>Attitude towards male involvement in contraceptive uptake( Grades)</b>		
positive (75% and above)	100	40
Negative (below 50%)	150	60
<b>men and women should make decisions jointly about contraceptive uptake in the family</b>		
Agree	69	27.6
Disagree	181	72.4
<b>male partner involvement will ensure successful uptake and continuation rates</b>		
Agree	31	12.4
Disagree	219	87.6
<b>male partners should share the responsibility of contraceptive uptake and use</b>		
Agree	68	27.2
Disagree	182	72.8

## **4.5 Factors Influencing Male Partner Involvement in Contraceptive Uptake**

### **4.5.1 Socio-demographic and Economic Factors of Respondents and Male Partner Involvement in Contraceptive Uptake**

The study findings showed that there was a significant relationship between age, level of education, age when started living with a woman on the other hand and male partner involvement in contraceptive uptake on the other. Table 4.5 shows the bivariate analysis of association between selected socio-demographic characteristics and male partner involvement in contraceptive uptake. Male respondents who were aged less than 30 years were found to be almost three times more likely to be involved in contraceptive use with their spouses on the one hand [OR=2.76; 95%CI=1.03 - 7.43; P=0.044] and respondents aged 30 - 39 years were found to be almost twice more likely to be involved in contraceptive use by their spouses [OR=2.82; 95%CI=1.11 - 7.15; P=0.029] compared to those respondents who were 50 years and above as shown in table 4.7. This was also captured from the FGD where a participant had this to say *“You will find that the younger male partners are more interested because they want to take charge and know what is happening with their spouses, they even want to accompany them to the facility where they are going to get the contraceptive and they are not shy at all, I guess because they know that if they are not involved they may get very many children which they cannot take care of and economy is bad. Another participant noted that, “ you see, older people are not so involved with regards to contraceptive uptake because , they know their spouses are now mature , and they have knowledge on how not to get children and also they know maybe the children are now enough and are focusing on how to take care of the family.”*



**Table 4.4 Association Between Socio-Demographic and Economic Factors of Respondents and Male Partner involvement in Contraceptive Uptake**

Variables	Involved, (N=198)		No involved, (N=52)		OR	95% CI		p value*
	n	%	n	%		Lower	Upper	
<b>Age in years</b>								
<30 years	51	86.40%	8	13.60%	2.76	1.03	7.43	<b>0.044</b>
30 - 39 years	65	86.70%	10	13.30%	2.82	1.11	7.15	<b>0.029</b>
40 - 49 years	52	71.20%	21	28.80%	1.07	0.47	2.45	0.867
50 years and above	30	69.80%	13	30.20%	Reference			
<b>Level of education</b>								
None	30	78.90%	8	21.10%	0.58	0.22	1.5	0.261
Primary	37	86.00%	6	14.00%	0.95	0.34	2.64	0.927
Secondary	34	59.60%	23	40.40%	0.23	0.11	0.49	<b>&lt;0.001</b>
College	97	86.60%	15	13.40%	Reference			
<b>Current employment status</b>								
Salaried Job	15	88.20%	2	11.80%	0.94	0.12	7.52	0.952
Self Employed	118	81.40%	27	18.60%	0.55	0.12	2.52	0.438
Casual labor	49	70.00%	21	30.00%	0.29	0.06	1.38	0.121
Unemployed	16	88.90%	2	11.10%	Reference			
<b>Age when first started living with a woman</b>								
< 18 years	10	66.70%	5	33.30%	Reference			
18 - 22 years	105	75.00%	35	25.00%	1.5	0.48	4.69	0.486
23 - 27 years	83	87.40%	12	12.60%	3.46	1.01	11.86	<b>0.048</b>
Key: OR = Odds Ratio; CI= Confidence Interval; *Significant at p<0.05 bolded								

On the other hand, the study findings showed that male partner involvement in contraceptive uptake was significantly lower among respondents with secondary level of education compared to those with college level of education [OR=0.23; 95%CI=0.11 - 0.49; P<0.001].

Respondents who started living with a woman at the age of 23 - 27 years were found to be almost four times more likely to be involved in contraceptive use by their spouses compared to those who started at age of less than 18 years [OR=3.46; 95%CI=1.01 - 11.86; P=0.048].

#### **4.5.2 Knowledge and Male Partner Involvement in Contraceptive Uptake**

The study findings showed that male partner knowledge on methods that could be used to delay a pregnancy was significant to male partner involvement in contraceptive uptake. The respondents who knew of any methods that could be used to delay pregnancy were more likely to be involved in contraceptive use by their spouses compared to those who did not know [OR=12.78; 95%CI=2.50 - 65.38; P=0.001] This was also captured from a key informant who said “*Sometimes the men who accompany their spouses to the family planning clinic were asking questions about the different methods that they knew or had heard of and wanting to know which one is the best, indicating that they know of the different available methods*”. Similarly, male partners who were knowledgeable on family planning method(s) used by partner were found to be almost two times more likely to be involved in contraceptive use by their spouses as compared to those who had no knowledge [OR=2.81; 95%CI=1.47 - 5.37; P=0.002].

<b>Table 4.5: Association Between Knowledge and Male Partner Involvement in Contraceptive Uptake</b>								
Variables	Involved, (N=198)		No involved, (N=52)		OR	95% CI		p value*
	N	%	n	%		Lower	Upper	
<b>Awareness of any methods that could be used to delay pregnancy</b>								
Yes	196	81.0%	46	19.0%	12.78	2.50	65.38	<0.001
No	2	25.0%	6	75.0%	Reference			
<b>Knowledge on family planning method(s) (grade)</b>								
Excellent	12	66.7%	6	33.3%	Reference			
Good	79	79.8%	20	20.2%	1.97	0.66	5.91	0.224
Poor	107	80.5%	26	19.5%	2.06	0.71	6.00	0.186
<b>Knowledge on family planning method(s) used by partner</b>								
Knows	157	84.0%	30	16.0%	2.81	1.47	5.37	<b>0.002</b>
Don't know	41	65.1%	22	34.9%	Reference			

### **4.5.3 Influence of Attitudes, Myths and Misconceptions and Male Partner Involvement in Contraceptive Uptake**

The study findings showed that respondents who disagreed on the question contraceptive uptake makes the woman infertile were found to be almost three times more likely to be involved in contraceptive uptake with their spouses [OR=2.61; 95%CI=1.38 - 4.91; P=0.003] compared to those who agreed. The scenario could be explained by a key informant who said *“According to them, the men strongly believe the women could become infertile if they use any method, they really get involved first by strongly opposing the general idea of use of family planning methods or by resorting to use of more natural method and this greatly contributes to either use or non-use of contraceptive methods.* “Similarly, male partners who disagreed that women who use contraception may become promiscuous were found to be almost four times more likely

to be involved in contraceptive use by their spouses compared to those who agreed [OR=2.53; 95%CI=1.35 - 4.72; P=0.004]

<b>Table 4.6: Attitudes, Myth/Misconception and Male Partner Involvement in Contraceptive Uptake</b>								
<b>Percentage distribution of respondents who agreed or disagreed to statements assessing attitude of male partners.</b>								
Variables	Involved, (N=198)		No involved, (N=52)		OR	95% CI		p value*
	n	%	n	%		Lower	Upper	
<b>Contraceptive uptake is purely a women's affair and men should not be involved</b>								
Agree	84	33.6%	19	7.6%	1.28	0.68	2.41	0.443
Disagree	114	45.6%	33	13.2%	Reference			
<b>Contraceptive uptake makes the woman infertile</b>								
Agree	49	19.6%	24	9.6%	Reference			
Disagree	149	59.6%	28	11.2%	2.61	1.38	4.91	<b>0.003</b>
<b>Contraceptive is a western idea and goes against the norm of religious teachings</b>								
Agree	62	24.8%	18	7.2%	0.86	0.45	1.64	0.650
Disagree	136	54.4%	34	13.6%	Reference			
<b>Women who use contraception may become promiscuous</b>								
Agree	73	29.2%	31	12.4%	Reference			
Disagree	125	50.0%	21	8.4%	2.53	1.35	4.72	<b>0.004</b>
<b>Key: OR = Odds Ratio; CI= Confidence Interval; *Significant at p&lt;0.05 bolded</b>								
*Total of 103 respondents agreed that contraceptive uptake is purely a women's affair and men should not be involved. However 33.6% of the respondents who agreed were involved in contraceptive use with spouse whilst 7.6% were not involved.								

#### **4.5.4 Gender Biases and Poor Attitude of Service Providers and Male Partner Involvement in Contraceptive Uptake**

Bivariate analysis of gender biases and poor attitude of service providers with male involvement showed that respondents who agreed that service providers would not regard them as weak if they accompany their partner to the family planning clinic were

more likely to be involved in contraceptive use by their spouses as compared to those who agreed. [OR=2.18; 95%CI=1.17 - 4.05; P=0.013].

Respondents who agreed that service providers would not regard them as weak if they accompany their partner to the family planning clinic and got involved in contraceptive use with their spouses accounted for 27.6% of the total while those who disagreed and got involved accounted for 51.6% of the total, hence total respondents who were involved despite agreeing or disagreeing accounts for 79.2% Respondents who agreed that health service providers' attitude would encourage male partner involvement were more likely to be involved in contraceptive use by their spouses as compared to those who disagreed [OR=2.93; 95%CI=1.25 - 6.86; P=0.010]. On the other hand respondents who disagreed that women who use contraceptives may become promiscuous were found to be four times more likely to be involved in contraceptive use by their spouses as compared to those who agreed, [OR=2.53; 95%CI=1.35 - 4.72; P=0.004]

Variables	Involved, (N=198)		No involved, (N=52)		OR	95% CI		p value*
	n	%	n	%		Lower	Upper	
	<b>Service providers will not regard you as weak if you accompany your partner to the family planning clinic?</b>							
Agree	69	71.1%	28	28.9%	Reference			
Disagree	129	84.3%	24	15.7%	2.18	1.17	4.05	<b>0.013</b>
<b>In your opinion do you think the health service providers attitude encourage male partner involvement?</b>								
Yes	62	89.9%	7	10.1%	2.93	1.25	6.86	<b>0.010</b>
No	136	75.1%	45	24.9%	Reference			
<b>In the community it is thought that only women should be concerned with matters of contraceptives uptake?</b>								
Yes	139	83.2%	28	16.8%	2.02	1.08	3.77	<b>0.026</b>
No	59	71.1%	24	28.9%	Reference			
Key: OR = Odds Ratio; CI= Confidence Interval; *Significant at p<0.05 bolded								

#### **4.5.5 Strategies for Male Partner Involvement in Contraceptive Uptake**

Focus group discussions and key informant interviews analyzed results listed some factors that could facilitate men's involvement in contraceptive uptake with their spouses as, government policy regarding men's role in FP, provision of more FP clinics that are men friendly, and adequate sensitization for men on the importance of their involvement in contraceptive use with their spouses. Other facilitating factors were positive attitude of health workers, involvement of male religious leaders to advocate for men involvement in contraceptive uptake. FGD participants also suggested that health services providers should have positive attitude towards men. This was also captured from the FGD participant who had this to say

*“Necessary authority should try and improve the attitude of the medical personnel especially the nurses because majority of them do not have good behaviors to men who*

*come with their wives to the clinic, they look at you as if you are not a busy person and almost as if you are not supposed to be there, it is not good that is the major reason why I hate going to health center.* “Another participant in older group said: *“The way we can encourage men to follow their wives to FP clinic is if government can educate their health personnel to change their attitude towards their clients.”* On the other hand another participant said that: *“you know, most of the times, many men do not know that they should participate and actually do something when time has come when the wife must use contraceptives so that another child is not borne, so they do nothing, however, me I know that when information is spread out there on the reasons why the support of men is important, most of them are clever and they will see the need. So for now information should be spread everywhere so that men can hear it”*

According to the findings in the study, there should be information targeting men so as to promote male involvement in contraceptive uptake. The study showed that, men’s lack of involvement was blamed on family planning services, including awareness-raising campaigns, which have traditionally targeted mostly women. The respondents reported that this was thought to further define contraceptive use as a woman’s domain, including initiating partner discussions and managing contraception, such that if the woman does not deliberately involve the man, then no involvement occurs with the spouse with regards to contraceptive use.

In cases where male involvement was perceived appropriate, lack of knowledge about how to be involved was often cited by participants as another deterrent for men and

hence the best strategy would be to create mass awareness campaigns on the importance of male involvement. One respondent said: *“Men are not involved in family planning and promotion of contraceptive use because they lack information. It is common for women to be sensitized because they go for clinics, but the men do not go for clinics. There are only few who go there. Here in East Leigh, there are no sensitizations targeting us men by anybody. It is only a few women who talk to their men, and they can’t explain to them very well”*. Male FGD Participant, East Leigh. *“Sensitize all men about involvement in contraceptive uptake and also train them about their roles when it comes to family planning. By doing so, they will come to know the importance of male partner involvement in contraceptive uptake, as most have no idea at all”*. Female Key Informant, East Leigh Nursing Home.

## **4.7 Discussion**

### **4.7.1 Demographic and Socio-economic Factors Influencing Male Partner Involvement in Contraceptive Uptake**

According to the study findings, the urban Somali refugee men level of involvement in contraceptive uptake was above average. This research demonstrated that on the one hand 79.2% of the male partners interviewed were involved in contraceptive uptake with their spouses and on the other hand, 20.8% were not involved in contraceptive uptake. Further analysis of socio demographic variables demonstrated a significant relationship between the age of respondents and male involvement in contraceptive uptake amongst urban Somali refugees in east Leigh. According to the findings, male respondents who were aged less than 30 years were found to be almost three times more



likely to be involved in contraceptive use with their spouses as compared to those who were above 50 years. Respondents who had attained at least secondary level of education were twice more likely to be involved in contraceptive use with their spouses compared to those who had not. These study findings corroborates a similar study finding in southeast Nigeria which showed that socio-demographic variables like male partners level of education had positive association for influencing male partner involvement in contraceptive uptake (Adelekan et al., 2014).

This study however did not find association of age when started living with partner and age of the respondent with male partner involvement in contraceptive uptake. Similar findings were shown in a study done in west pokot which revealed that the education level of the respondent was also significantly associated with the level of male involvement in contraceptive uptake. Having no education made a male partner 4 times less likely to be involved in contraceptive use with their spouses. It also showed that the respondent's age was significantly associated with level of involvement in contraceptive uptake with their spouses. (Butto et al 2015). This finding however contradicted (Green and J. Chens 2014) study on male involvement in reproductive health in Indonesia which did not find any association between age of the respondents and involvement in contraceptive uptake but found that confounding variables like education on age influenced involvement. They found that younger respondents aged 30 years and below with at least college education were 3 times more likely to be involved in contraceptive use with their spouses.

At the same time although, majority of the respondents were self-employed. There was however no significant association between the source of income and male involvement in contraceptive uptake in the study. This corroborates a previous finding in Kisumu which showed that source of income does not influence male partner involvement.(Nzioka 2015).This could be due to the fact that most family planning services are free in government facilities and fairly affordable in other health facilities within eastleigh. According to the results from the studies it is therefore important to target younger respondents since they are the ones who most of the times are starting families and hence if they know the importance of male involvement they will have excellent involvement in contraceptive uptake amongst urban Somali refugees.

#### **4.7.2 Knowledge and Male Partner Involvement in Contraceptive Uptake**

According to the study findings, the overall knowledge score amongst the respondents interviewed was excellent. Male partners were asked if they knew the available methods of contraception and 97% responded yes. The findings from the study indicated that knowledge of the methods of contraceptives significantly influenced male partner involvement in contraceptive uptake. The respondents who knew of some methods that could be used to delay pregnancy were three times more likely to be involved in contraceptive uptake with their spouses than those who did not know of any method to delay a pregnancy.

Similarly, male partners who were knowledgeable on family planning method(s) used by partner were found to be almost two times more likely to be involved in

contraceptive use by their spouses as compared to those who had no knowledge. These findings in this study corroborates a study done in Uganda which showed that male partners who knew of appropriate contraceptive methods that could be used to delay a pregnancy were three times more likely to be involved in contraceptive use by giving positive approval for their spouses to use contraceptives.(Kabagenyi et al., 2014). The key informants interviewed during the study also stated that the “*men who had knowledge generally encouraged their spouses to use contraceptives since it was not an area that was new to them.*”

The findings from this study is also similar to the findings of a study carried out in western Kenya to determine the factors influencing male involvement in sexual and reproductive health which showed that, the male partners who knew both the benefits of contraceptive use and some methods that could be used to delay a pregnancy were three times more likely to be involved in contraceptive use than those who did not (Onyango et al, 2014). The findings are also consistent with a research done in Ethiopia which reported that male involvement was high amongst respondents with knowledge on the importance of male spouses’ inclusion in family planning programs (A. Berhane et al 2015). However the findings are inconsistent with the result of the study done in Budondo, Uganda, which reported male involvement was not influenced by the knowledge level of male spouses either on appropriate contraceptives available nor knowledge on benefits but it was shown that attitude that contraceptive use or uptake was supposed to be a women’s affair and hence men had no role to play with regards to contraceptive use or non-use. One Fgd participant said that,; “*you know here most*

*people know very well what these contraceptives are and their use, however nobody is concerned with them., it is the work of the women to ensure that she does not get too many children and at the same time please the husband because that is her role, why she has been married there.”* (Jangu, 2013). In conclusion it is evident that excellent knowledge on benefits and methods of contraceptives will influence involvement in contraceptive use or non-use but at the same time other confounding variables can also be of importance to look at.

#### **4.7.3 Attitudes, Myths and Misconceptions and Male Partner Involvement in Contraceptive Uptake**

According to the study findings, the male partners had a negative attitude towards involvement in contraceptive uptake based on the statements assessing attitude. Male partners attitudes about their roles in contraceptive uptake decision-making were assessed on a two-tier scale of agree and disagree. Accordingly, most male respondents 72.4% disagreed that men and women should make decisions jointly about contraceptive uptake in the family; 87.6% disagreed that male partner involvement will ensure successful uptake and continuation rates; 72.8% disagreed that male partners should share the responsibility of contraceptive uptake and use.

The study findings showed that generally male partners had a negative attitude towards men involvement considering it a woman affairs since most information and knowledge regarding FP was mostly targeting woman. This corroborated study findings in a study done in Uganda which showed that negative attitude derived from limited knowledge

on the importance of male involvement, misconceptions and myths surrounding the FP methods often prevent men and women from making a decision to adopt FP methods, (Kasedde, 2014). The findings from the male involvement study in Eastleigh is also in agreement with a study in Ghana, which showed that on the one hand, the husband's attitudes and approval plays a big impact on the spouse uptake of contraception and on the other hand some myths and misconceptions also regarding male involvement in contraceptives. According to some respondents in the FGD, they believed that contraception could make one have an abnormal child later on and that it was a western idea which should not be allowed to happen. A similar study done in Uganda revealed that Family planning methods are surrounded by myths and misgivings e.g. that (IUCD) may get lost in the womb or a child may be born with it stuck on the head and so it should not be supported by anyone including the spouses(Jangu, 2013).

#### **4.7 4 Strategies for Increasing Male Involvement in Contraceptive Use**

Focus group discussions and key informant interviews analyzed results listed some factors that could facilitate men's involvement in contraceptive uptake with their spouses as, government policy regarding men's role in FP, provision of more FP clinics that are men friendly, and adequate sensitization for men on the importance of their involvement in contraceptive use with their spouses. These results corroborates a similar finding in Mpigi district of Uganda which showed that perceptions that reproductive health was a woman's domain can successfully be changed by adequate communication geared towards men as a discreet group in order to promote male involvement in contraceptive use.

## **CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS**

### **5.1 Introduction**

This study aimed at determining male partner involvement in contraceptive uptake amongst urban Somali refugees in east Leigh. This chapter focuses on the findings, conclusion, recommendations and suggestions for further studies.

### **5.2 Summary**

The study findings showed that the knowledge of male partners concerning contraceptive methods was high while practices were low. According to this study 97 % of the respondents were aware of the available methods of contraception, however yet again, 85% of respondents had the feeling that men should not be involved in contraceptive uptake. According to this study 79.2 % of male partners were involved in contraceptive uptake. Several factors were shown as the likely factors associated with male partner involvement in contraceptive uptake. The demographic and socio-economic factors that influenced male partner involvement included age, level of education and age when living with a woman started. The study also showed that FP clinics are not men friendly and most men perceive FP services to be for women only. The attitude of male spouses to involvement in contraceptive use was negative. Majority of the Somali refugee men perceived contraceptive uptake and use as a woman affair and if they accompany their wives to the FP clinic they will be perceived as weak or over ruled by their women. Finally, the study revealed that in cases where male involvement was perceived appropriate, lack of knowledge about how to be involved

was cited by participants as another deterrent for men and hence the best strategy would be to create mass awareness campaigns on the importance of male involvement and how best to be involved in contraceptive use with their spouses.

### **5.3 Conclusion**

According to the study findings, male involvement in contraceptive use with their spouses was high on the one hand and attitude of the male spouses towards male involvement in contraceptive use with their spouses was negative. A total of 53.6% male partners made contraceptive decisions jointly with their spouses.

This is a very interesting find because it shows that there could be other reasons triggering involvement despite the negative attitude they have towards male partner involvement in contraceptive use and uptake.

### **5.4 Recommendations**

In order for male partner involvement in contraceptive uptake amongst urban Somali refugees in Kenya to increase, the Ministries of Health, Non-Governmental Organizations, Faith Based Organizations and other stakeholders should;

1. Put in place IEC strategies to address male partner attitudes in order to encourage involvement. A well-designed and well-focused IEC campaign can have a positive impact on men by increasing their knowledge and improving their attitudes toward involvement in contraceptive use with their spouses.
2. The government should setup male friendly reproductive health clinics and encourage men to be involved in FP services

3. Engage community, religious and opinion leaders so that they can advocate for male partner involvement in contraceptive uptake.

#### **5.4 Further Research**

1. Research on the best approach to making male partner involvement in contraceptive uptake more acceptable by urban Somali refugee men and the society.
2. Research to determine male partners perception on utilization of more male specific contraceptive methods like vasectomy
3. More research is needed regarding how to achieve positive attitude of male partner towards involvement in contraceptive uptake among urban Somali refugees in programmatic settings.



## REFERENCES

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**APPENDICES**  
**APPENDIX 1: WORK PLAN**

ITEM	ACTIVITY	August	Sept	Oct	April	May	SEP	OCT
		2013	2013	2014	2014	2014	2017	2017
1.	Concept writing							
2.	Literature review							
3.	Proposal writing							
4.	Proposal Defense							
5.	Submit thesis Proposal to the Ethical review Committee							
6.	Data collection							
7.	Data analysis & report writing							
8.	Presentation of report and defense							

**KEY****MONTHS IN ORDER**

- A     AUGUST 2013
- S     SEPTEMBER 2013
- O     OCTOBER 2013
- A     APRIL 2014
- M     MAY 2014
- J     MAY 2017
- J     JUNE 2017

**APPENDIX 2: RESEARCH BUDGET**

<b>NO.</b>	<b>ITEM</b>	<b>TOTAL COST</b>
1.	Research Proposal Writing	
	• Stationary, Printing and Binding	Kshs. 5000.00
2.	Data Collection	
	• Pilot Study	Kshs. 15000.00
	• Actual Study	Kshs. 50000.00
	• 6Research Assistants	Kshs. 60000.00
	• Airtime, Meals and Transport	Kshs. 5000.00
	• Participants reward	Ksh 62500.00
3.	Data Analysis	
	• STATA Data entry and Analysis	Kshs. 10000.00
	• 1 Flash Disk	Kshs. 1000.00
4.	Research Report Writing	
	• Stationary, Printing and Binding	Kshs. 5000.00
	Subtotal	Kshs. 151000.00
5.	Miscellaneous (10% of subtotal)	Kshs. 15100.00
	<b>TOTAL</b>	<b>Kshs. 228,600.00</b>

### **APPENDIX 3: INFORMED CONSENT**

My name is Ameso Ruth Anyango. I am a Masters student from Kenyatta University. I am conducting a study on male partner involvement in contraceptive uptake amongst urban Somali refugees in Eastleigh, Nairobi County, Kenya'. This information will be used by the Ministry of health and sanitation to improve access of contraceptive methods for refugees in 'Eastleigh and other regions.

#### **PROCEDURES TO BE FOLLOWED**

Participation in this study will require that I ask you some questions regarding the study. I will record the information from you in the questionnaire.

You have the right to refuse to participate in this study. Please remember that participation in this study is voluntary. You may ask questions related to the study at anytime.

You may refuse to respond to any questions and you may stop the interview at any time.

#### **DISCOMFORTS**

Some of the questions you will be asked may be on intimate subject and may be embarrassing or make you uncomfortable, if this happen; you may refuse to answer these questions if you choose. You may also stop the interview at any time. The interview may take almost 45minutes.

#### **BENEFITS**

If you participate in this study, you will greatly help us learn the factors influencing male partner involvement in contraceptive uptake amongst urban Somali refugees in Eastleigh, Nairobi County and help family planning service providers, provide effective services that will improve access to FP services.

**REWARD**

No reward in form of monetary gains will be advanced to participants who willing consent to participate in the study; however, the researcher will take steps to transport FGD participants to the venue at Mariestopes clinic and will also provide refreshments at her cost, or a reimbursement of equivalent amount where the participants come with their own means

**CONFIDENTIALITY**

The interviews will be conducted confidentially and individually. Your name will not appear or be recorded in the questionnaire. The questionnaires will be kept in a locked cabinet for safe keeping at Kenyatta University. Everything will be kept private.

**CONTACT INFORMATION**

If you have any questions you may contact DrAkunga on 0722552157 or DrOkelloAgina on 0722526728 or the Kenyatta University Ethical Review Committee Secretariat on [kuerc@ku.ac.ke](mailto:kuerc@ku.ac.ke).

**PARTICIPANTS STATEMENTS**

The above information regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in the study is entirely voluntary. I understand that my records will be kept private and that I can choose to stop participating in the study at any time.

**NAME OF PARTICIPANT**.....

**SIGNATURE/ORTHUMB**

**PRINT**.....**DATE**.....



**INVESTIGATORS STATEMENT**

I under signed, have explained to the volunteer in a language s/he understands, the expectations from the participants by me in the study and the benefits involved

**NAME OF INTERVIEWER** .....

**INTERVIEWER**

**SIGNATURE** ..... **DATE** .....

## **APPENDIX 4: REFUGEE LEADER QUESTIONNAIRE**

**Male partner involvement in contraceptive uptake amongst urban Somali refugees in Eastleigh: Nairobi country.**

**Refugee Leader Questionnaire**

**Date:**

**Leader's name:**

**Male** \_\_\_ **Female** \_\_\_ (please check)

**Position in the community/title:**

**Location:**

**Interviewer's name:**

**INTRODUCTION:** Thank you for allowing me to interview you. I appreciate your time and good gesture. My name is \_\_\_\_\_. I am conducting a research on factors influencing male partner involvement in contraceptive uptake amongst urban Somali refugees here in Eastleigh

**PURPOSE:** The purpose of this overall exercise is to identify the barriers for women and men in terms of male partner involvement to contraceptive uptake

Findings from all of our work in different settings will be summarized to describe the state of male partner involvement in contraceptive uptake amongst this community

**SELECTION:** We are conducting interviews among those who have key perspectives on this issue. You have been identified as an interviewee because of the key role you play in the community. We value the perspectives you can offer.

**VOLUNTARY PARTICIPATION:** Your participation in this exercise by being interviewed is voluntary. You may decide to participate or not.

Although we will greatly value your participation, you will not experience negative consequences by not participating. You may stop the interview at any time if you feel uncomfortable.

**PROCEDURES AND USE OF INFORMATION:** We will ask you a series of questions on your thoughts on contraceptives and your community's access to services. There is no wrong or right answer to the questions, so please do not worry if you are not sure about the answers. All of the individual information I collect will be kept confidential and will not be traced back to you. Your honest response will be very much appreciated.

I would like to ask you some questions about women's health.

1. Have you ever heard of contraceptives? Probe: What have you heard about it
2. What does the community think about contraceptive use?
3. In your community, are male partners allowed to be involved in contraceptive use with their spouses?
4. In your community, **how many** children should a woman or family have?
5. Within the family, who decides how many children the family should have?  
Probe: What are some of the things the person(s) think(s) about in deciding the number of children a family should have?
6. **What** contraceptive methods do you know?
7. What are some benefits of spacing children and births?
8. How many years should births be spaced?
9. **What** does the community male think about use of contraceptive?

Are family planning services **available** in your community?

Probe: For whom are they available?

Probe: Where can someone go for contraceptive information and services?

10. What problems or challenges, if any, are community members experiencing in male partner involvement in contraceptive uptake?
11. Do many male partners in this community get involved in issues of contraceptive uptake?
12. **Who** decides whether a woman will practice contraceptive uptake?
13. How is this different if the person is not married?
14. What would you suggest would help community members to completely embrace the concept of male partner involvement in contraceptive uptake?

#### **CLOSING STATEMENT**

Thank you. Those were all of my questions for now. Do you have anything you would like to add? Do you have any questions for us? Do you have any questions that you think should be asked of other groups or individuals?

**THANK YOU FOR YOUR TIME AND FEEDBACK**

## APPENDIX 5: QUESTIONNAIRE

### MALE PARTNER INVOLVEMENT IN CONTRACEPTIVE UPTAKE AMONGST URBAN SOMALI REFUGEES QUESTIONNAIRE

001 Questionnaire Identification Number |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

**Start Time:** \_\_\_\_\_

002 Interviewer: Name \_\_\_\_\_

003 Date of Interview: \_\_\_\_ \_\_\_\_ / \_\_\_\_ \_\_\_\_ / \_\_\_\_ \_\_\_\_

Day            Month            Year

004 Data Entered By: Name \_\_\_\_\_

#### **A: Structured Questionnaire**

**INTRODUCTION:** Thank you for allowing me to interview you. My name is - \_\_\_\_\_ . I am conducting a research on factors influencing male partner involvement in contraceptive uptake amongst urban Somali refugees here in Eastleigh It is a survey among the urban refugees and you are asked to be very honest with your answer bearing in mind that we will not write your name in this questionnaire. The responses you will give will be very confidential and will be used for the purposes of the study only.

**VOLUNTARY PARTICIPATION:** Your participation in this exercise by being interviewed is voluntary. You may decide to participate or not. Although we will greatly value your participation, you will not experience negative consequences by not participating. You may stop the interview at any time if you feel uncomfortable

#### **SOCIO DEMOGRAPHIC INFORMATION**

- |                               |           |       |         |       |
|-------------------------------|-----------|-------|---------|-------|
| 1. Highest Level of Education | Madrasaa  | [ ] 1 | Primary | [ ] 2 |
|                               | Secondary | [ ] 3 | College | [ ] 4 |
| 2. Age of respondent in years | 15 – 19   | [ ] 1 | 20 – 24 | [ ] 2 |
|                               | 25 – 29   | [ ] 3 | 30 – 34 | [ ] 4 |

- 35 – 39 [ ] 5      40 – 44 [ ] 6  
 45– 49 [ ] 7      above 50 [ ] 8
3. Marital Status Single [ ] 1      Married monogamous [ ] 2  
 Married polygamous [ ] 3      Separated/Divorced. [ ] 5      Widowed [ ] 6
4. What is Your Religion? Catholic [ ] 1      Protestant [ ] 2  
 Muslim [ ] 3      Other (Specify) ... [ ] 4

**PART 1 SOCIO-ECONOMIC AND CULTURAL INFORMATION.**

1. How long have you been living in Eastleigh as a refugee?.....
2. Current employment status: Salaried job [ ] 1      Self-employment [ ] 2  
 Casual labor [ ] 3      Housewife [ ] 4  
 Unemployed [ ] 5
3. How Much Income Do You Earn Per Month? 0 – 5000 [ ] 1  
 5000 –10000 [ ] 2  
 10000 – 20000 [ ] 3  
 20000–30000 [ ] 4  
 30000-40000 [ ] 5  
 above 40000 [ ] 6
4. How old were you when you first started living with a woman. Age in years  
 (.....)
5. What Is the Highest level of education that you're current or most recent  
 partner achieved?  
 Madrasa [ ] 1      Primary [ ] 2      Secondary [ ] 3      College /Campus [ ] 3

**SECTION 2****MALE PARTNER PRACTICE**

1. Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy.

Do you know of any methods that could be used to delay pregnancy?

Yes  1      No  2      don't know  3

a) If yes please give some examples.....

Female Sterilization  1 Pill  2 IUD  3  
 Implants.  4 Male Condom  5 Female Condom.  6  
 Lactational  7 Rhythm Method  8 Withdrawal  9  
 Vasectomy  10

b) Is your partner currently using any form of contraceptives?

Yes  1 No  2 don't know  3

c) If yes which method is your partner currently using or has ever used?( Tick All Mentioned)

Female Sterilization  1 Pill  2 IUD  3  
 Implants  4 Male Condom  5 Female Condom.  6  
 Lactational Amenorrhoea  7 Rhythm Method  8 Withdrawal  9

d) Who usually makes decisions about health care in the family?

You  1  
 Your partner  2  
 You and your partner jointly  3  
 Someone else  4

e) Do you give your partner permission before they make a decision regarding contraceptive uptake      Yes [ ]1    No [ ]2

f) Male partners are actively involved in decision making for contraceptive use in this community?

Strongly Agree [ ]1    Agree [ ]2

Disagree [ ]3    Strongly Disagree [ ]4

g) Women are discouraged by their partners from using contraceptives in this community?

Strongly Agree [ ]1    Agree [ ]2

Disagree [ ]3    Strongly Disagree [ ]4

h) In this community has there been a situation where you feel or members feel that men should not been actively involved in issues of contraceptive uptake?

Yes [ ]1    No [ ]2

i) In your opinion what are some of the reasons why contraceptive may not be fully embraced?

Religious reasons [ ]1    Method does not work [ ]2

Methods bring for her health problems [ ]3    Cannot afford the method [ ]4

Wants more children [ ]5    Will cause infertility [ ]6

### **SECTION 3:**

#### **THE FACTORS INFLUENCING MALE PARTNER INVOLVEMENT**

##### **1. Accessibility**

a) Do you know of a place where you can obtain a method of family planning?

Yes [ ]1    No [ ]2



b) Where is that?

- |                     |       |                     |       |
|---------------------|-------|---------------------|-------|
| Private Sector      | [ ] 1 | Government Hospital | [ ] 2 |
| Faith-Based Mission | [ ] 3 | Pharmacy/Chemist    | [ ] 6 |
| Any Other Place     | [ ] 5 |                     |       |

c) How long does it take from your home to reach the facility?

- a) Less than 30 minutes  
 b) Approximately 1 hr.  
 c) Above 1 hr.  
 d) More than 2hrs

d) Where did your partner obtain (CURRENT METHOD) when she started using it?

- |                        |       |
|------------------------|-------|
| Public Sector          | [ ] 1 |
| Government Hospital    | [ ] 2 |
| Other Public           | [ ] 3 |
| Private Medical Sector | [ ] 4 |
| Faith-Based Mission    | [ ] 5 |
| Pharmacy/Chemist       | [ ] 6 |
| Nursing/Maternity Home | [ ] 7 |

e) Do you know if she was ever told by a health or family planning worker about side effects or problems she might have with the method?

- Yes [ ] 1    No [ ] 2

f) If yes which one of this has she ever experienced?

- |                   |       |                     |       |
|-------------------|-------|---------------------|-------|
| Depression        | [ ] 1 | Backache            | [ ] 2 |
| Acne              | [ ] 3 | Weight gain         | [ ] 4 |
| Irregular periods | [ ] 5 | High blood pressure | [ ] 6 |
| Jaundice          | [ ] 7 | Loss of vision      | [ ] 8 |

Vomiting [ ] 9

- g) How would you rate the appropriateness of the physical location of the family planning facility?

Excellent [ ] 1 Good [ ] 2 Average [ ] 3 Poor [ ] 4 Don't know [ ] 5

- h) How would you rate the convenience of the facility for partners wanting to accompany their wives?

Excellent [ ] 1 Good [ ] 2 Average [ ] 3 Poor [ ] 4 Don't know [ ] 5

- i) Do you experience shortage of contraceptive supplies/commodities when you visit service provider? Yes [ ] 1 No [ ] 2

- j) How would you rate the overall charges and cost for contraceptive commodity?

Excellent [ ] 1 Good [ ] 2 Average [ ] 3 Poor [ ] 4 Don't know [ ] 5

## 2. Myth and Misconceptions

- a) Contraceptive uptake is purely a women's affair and men should not be involved

Strongly Agree [ ] 1 Agree [ ] 2

Disagree [ ] 3 Strongly Disagree [ ] 4

- b) Contraceptive uptake makes the woman infertile

Strongly Agree [ ] 1 Agree [ ] 2

Disagree [ ] 3 Strongly Disagree [ ] 4

- c) Contraceptive is a western idea and goes against the norm of religious teachings

Strongly Agree [ ] 1 Agree [ ] 2

Disagree [ ] 3 Strongly Disagree [ ] 4

d) Women who use contraception may become promiscuous.

Strongly Agree [ ] 1                      Agree [ ] 2

Disagree [ ] 3                      Strongly Disagree [ ] 4

### 3) Gender Biases and Poor Attitude of service providers

a) Do you think service providers will regard you as weak if you accompany your partner to the family planning clinic?                      Yes [ ] 1      No [ ] 2

b) In your opinion do you think the health service providers attitude encourage male partner involvement?

Yes [ ] 1      No [ ] 2

c) In this community is it thought that only women should be concerned with matters of contraceptives uptake?

Yes [ ] 1      No [ ] 2

### 4) Inter-spousal Discussion about Family Planning

a) Is contraceptive uptake discussed freely between you and your partner?

Yes [ ] 1      No [ ] 2

b) What issues do you discuss with your partner regarding contraceptives?

i. when to prevent pregnancy with contraceptives

ii. The best contraceptive option to use

iii. Benefits of contraceptives use

### 5) Contraceptive choices available for men

a) Are you aware of vasectomy and condoms as male methods of fertility regulation?

Yes [ ] 1                      No [ ] 2

### 6) Partner approval before contraceptives use

a) Do you support use of contraceptives by your partner? Yes [ ] 1      No [ ] 2

b) Do you have to approve to your partner before she uses any contraceptive methods Yes [ ] 1      No [ ] 2      neutral { } 3

**If yes**

c) What reasons do you have for disapproval to your partner before using any contraceptives?

- a) Desire to have more children
- b) Fear of side effects
- c) Religious prohibition
- d) It is only the issue of women

APPENDIX 6: MAP OF STUDY AREA; EASTLEIGH, NAIROBI, KENYA



**APPENDIX 7: GRADUATE SCHOOL APPROVAL**



**KENYATTA UNIVERSITY  
GRADUATE SCHOOL**

E-mail: [kubps@yahoo.com](mailto:kubps@yahoo.com)  
[dean-graduate@ku.ac.ke](mailto:dean-graduate@ku.ac.ke)  
 Website: [www.ku.ac.ke](http://www.ku.ac.ke)

P.O. Box 43844, 00100  
 NAIROBI, KENYA  
 Tel. 8710901 Ext. 57530

**Internal Memo**

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<b>FROM:</b> Dean, Graduate School	<b>DATE:</b> 10 <sup>th</sup> March, 2012
<b>TO:</b> Ms. Ameso Ruth Anyango C/o Community Health Dept.	<b>REF:</b> F139/20120/10
<b>SUBJECT:</b> APPROVAL OF RESEARCH PROPOSAL	

=====

This is to inform you that the Graduate School Board, at its meeting of 1<sup>st</sup> March, 2012, approved your research proposal for the M.P.H. degree entitled "Factors Influencing Male Partner Involvement in Contraceptive Uptake Amongst Urban Somali Refugees in Eastleigh, Nairobi County, Kenya."

You may now proceed with your data collection.

Thank you.

**JOHN M. ODONGI**  
**FOR: DEAN, GRADUATE SCHOOL**

c.c. Chairman, Community Health Dept.

Supervisors:

1. Dr. Daniel N. Akunga  
Department of Community Health
2. Dr. B. Okello Agina  
Department of Obstetrics & Gynaecology

JMO/cvw

---

*Committed to Creativity, Excellence & Self-Reliance*

## APPENDIX 8: RESEARCH AUTHORIZATION



Our Ref: P139/20120/10

Date: 10<sup>th</sup> March, 2012

The Permanent Secretary,  
Ministry of Higher Education, Science & Technology,  
P.O. Box 30040,  
**NAIROBI**

Dear Sir/Madam,

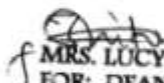
**RE: RESEARCH AUTHORIZATION**  
**MS. AMESO RUTH ANYANGO - REG. NO. P139/20120/10**

I write to introduce Ms. Ameso Ruth Anyango who is a Postgraduate Student of this University. She is registered for a M.P.H. degree programme in the Department of Community Health in the School of Public Health.

Ms. Ameso intends to conduct research for a Thesis entitled, "Factors Influencing Male Partner Involvement in Contraceptive Uptake amongst Urban Somali Refugees in Eastleigh, Nairobi County, Kenya."

Any assistance given will be highly appreciated.

Yours faithfully,

  
**MRS. LUCY N. MBAABU**  
**FOR: DEAN, GRADUATE SCHOOL**

LNM/cww

**APPENDIX 9: NACOSTI RESEARCH  
AUTHORIZATION**



**NATIONAL COMMISSION FOR SCIENCE,  
TECHNOLOGY AND INNOVATION**

Telephone: +254-20-2213471,  
2241349, 310571, 2219420  
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When replying please quote

9<sup>th</sup> Floor, Utalii House  
Uhuru Highway  
P.O. Box 30623-00100  
NAIROBI-KENYA

Ref: No.

Date:  
**3<sup>rd</sup> July, 2014**

**NACOSTI/P/14/4205/1967**

Ruth Anyango Ameso  
Kenyatta University  
P.O.Box 43844-00100  
**NAIROBI.**

**RE: RESEARCH AUTHORIZATION**

Following your application for authority to carry out research on "*Male partner involvement in contraceptive uptake amongst Urban Somali Refugees in Eastleigh, Nairobi County,*" I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for a period ending **15<sup>th</sup> December, 2014.**

You are advised to report to **the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

  
**SAID HUSSEIN**  
FOR: SECRETARY/CEO

Copy to:

The County Commissioner  
The County Director of Education  
Nairobi County.

**COUNTY COMMISSIONER**  
**NAIROBI COUNTY**  
P. O. Box 30124-00100, NBI  
TEL: 341666





## APPENDIX 10: KENYATTA UNIVERSITY ETHICS REVIEW APPROVAL



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Our Ref: KU/R/COMM/51/333

Date: 19<sup>th</sup> May, 2014

Ruth Anyango Ameso,  
 Dept. of Environmental Health,  
 Kenyatta University,  
 P.o Box 43844, Nairobi

**RE APPLICATION NUMBER PKU/197/1 174 – “MALE PARTNER INVOLVEMENT ON CONTRACEPTIVE UPTAKE AMONGST URBAN SOMALI REFUGEES IN EASTLEIGH, NAIROBI COUNTY, KENYA” – VERSION 2**

**1. IDENTIFICATION OF PROTOCOL**

The application before the committee is with a research topic “Male partner involvement on contraceptive uptake amongst urban Somali refugees in Eastleigh, Nairobi County, Kenya” – Version 2 dated 14<sup>th</sup> May, 2014.

**2. APPLICANT**

Ruth Anyango Ameso, Dept. of Environmental Health

**3. STUDY SITE**

Eastleigh, Nairobi County, Kenya

**4. DECISION**

The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines AND APPROVED that the research may proceed for a period of ONE year from 19<sup>th</sup> May, 2014.

**5. ADVICE/CONDITIONS**

- i. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
- ii. Serious and unexpected adverse events related to the conduct of the study are reported to this board immediately they occur.
- iii. Notify the Kenyatta University Ethics Committee of any amendments to the protocol.
- iv. Submit an electronic copy of the protocol to KUERC.

When replying, kindly quote the application number above

If you accept the decision reached and accept the conditions given please sign in the space provided below and return to KU-ERC a copy of the letter.

  
**PROF. NICHOLAS K. GIKONYO**  
 CHAIRMAN ETHICS REVIEW COMMITTEE



I .....accept the advice given and will fulfill the conditions therein.

Signature..... Dated this day of..... 2014.

cc. Vice-Chancellor  
 Director: Institute for Research Science and Technology