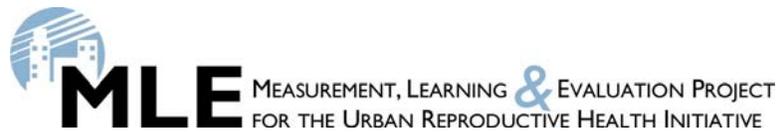


Your resource for urban reproductive health



## Measurement, Learning & Evaluation of the Urban Reproductive Health Initiative: Kenya, Mid-term Survey



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This report presents the findings from an analysis of the mid-term survey results from urban samples in three cities in Kenya. The report was written by the Measurement, Learning & Evaluation (MLE) Project of the Urban Reproductive Health Initiative. The MLE mid-term survey was implemented by the Carolina Population Center at The University of North Carolina at Chapel Hill and the African Population and Health Research Center. The Kenya Urban Reproductive Health Initiative (Tupange) is being implemented by a consortium led by Jhpiego.

The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the donor organization, the Bill & Melinda Gates Foundation. Additional information about this report may be obtained from:

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**List of Acronyms**

APHRC	African Population and Health Research Center
BCC	Behavior change communications
CHW	Community health worker
E-pill	Emergency contraception
FP	Family planning
ICRW	International Center for Research on Women
IUD	Intrauterine devices
KNBS	Kenya National Bureau of Statistics
LAM	Lactational amenorrhea method
LAPM	Long-acting and permanent methods
MLE	Measurement, Learning & Evaluation Project
RH	Reproductive health
SDM	Standard days method
SDP	Service delivery point survey
TBA	Traditional birth attendant
UNC-CH	University of North Carolina at Chapel Hill
URHI	Urban Reproductive Health Initiative

## Executive Summary

### *Background*

The global reproductive health community requires strong evidence to support the expansion and development of family planning programs in areas with high unintended pregnancy and maternal and infant mortality. The Bill & Melinda Gates Foundation's (BMGF) Reproductive Health (RH) Strategy aims to reduce maternal and infant mortality and unintended pregnancy in the developing world by increasing access to high-quality, voluntary family planning services. The BMGF-funded Urban Reproductive Health Initiative (Urban RH Initiative) is one component of the Foundation's RH Strategy. The Urban RH Initiative aims to increase modern contraceptive use in selected urban areas of Uttar Pradesh, India; Kenya; Nigeria and Senegal.

The Measurement, Learning & Evaluation (MLE) Project, led by the Carolina Population Center at the University of North Carolina in Chapel Hill (UNC-CH), in partnership with the International Center for Research on Women (ICRW) and the African Population and Health Research Center (APHRC), is undertaking the impact evaluation of the Urban RH Initiative's country-level programs.

In Kenya, the evaluation design includes a longitudinal survey with baseline, mid-term and endline surveys which follow a representative sample of currently married women that was scientifically selected from the five study cities of Nairobi, Mombasa, Kisumu, Machakos and Kakamega at baseline, covering both slum and non-slum areas. Baseline data were collected in the three initial intervention cities of Nairobi, Mombasa and Kisumu and the two control cities, Machakos and Kakamega, from September through December 2010 with a total of 8,932 women interviewed. At baseline, a cross-sectional sample of 2,503 men were interviewed in Nairobi, Mombasa and Kisumu. In addition, a facility-based survey was conducted in September 2011 drawing responses from 286 facilities in the five cities.

The mid-term data collection in the initial intervention cities of Nairobi, Mombasa and Kisumu provides Tupange with actionable measurements with which to decide on mid-course corrections, optimize program implementation to best meet the family planning needs of the urban poor and identify interventions for scale-up. At mid-term, MLE conducted individual surveys among the panel of women in the three cities, a cross-sectional sample of men in Mombasa, and surveys of health facilities and clients at Service Delivery Points (SDP) in Kisumu. Modifications to the original study design, such as streamlining the household surveys, were made in order to provide Tupange with timely results on key program questions on the potential population level effects of its activities. All women interviewed at baseline in Nairobi, Mombasa and Kisumu were eligible for interview at mid-term. A total of 3,207 baseline respondents from these three cities were successfully contacted and interviewed at mid-term, along with the new cross-section of 696 men from Mombasa. In addition, fifteen public and private facilities located in Kisumu East District and supported by the Tupange project were surveyed at mid-term.

### *Results*

#### **Household survey**

##### Family planning

At mid-term, current use of modern FP ranged from 34 percent in Mombasa to 56 percent in Kisumu. These percentages represent an increase in each of the three cities with the largest increase seen in Kisumu where overall use of FP rose from 48 to 61 percent. In Nairobi and Mombasa, increases in traditional method use constituted about half of the total gains in overall contraceptive prevalence although use of traditional methods remained much lower than modern methods. Large increases were seen in the use of the implant in particular; use more than doubled in Nairobi and Mombasa while Kisumu saw a three-fold increase from baseline. Of note, women in the lowest wealth quintiles in Nairobi and Mombasa experienced significant increases in the use of implants. By mid-term, nearly one in five women from the baseline survey had switched from non-use to a modern method at mid-

term. A greater percentage of women ages 15 to 24, never married women and women without children at the time of the baseline survey switched from no method to modern method use by mid-term.

The survey also captured changes in where women last obtained their method of FP at baseline and mid-term. Patterns at mid-term were mostly consistent with method sources at baseline. An exception was among implant users; a higher percentage at mid-term obtained the implant from the public sector in two cities than at baseline.

### Maternal and child health

Women were asked if they had been exposed to family planning information at the time of their last birth. Increases were seen in both the public and private sectors in all cities relative to baseline. The percentage of women who reported that they received no information or counseling at time of delivery in a public sector facility dropped between 6 and 15 percentage points. Results from the mid-term survey show that while most women did adopt a contraceptive method within 12 months of their last child delivery, about one in five women did not adopt FP within 12 months of the last delivery in Nairobi and Kisumu (22 percent); in Mombasa a total of 37 percent of women did not adopt any method.

### Demand generation

Brand recognition of the Tupange logo and media interventions was measured at mid-term and the results show broad penetration of messaging from all sources of media. Specifically, more than 60 percent of women could recall hearing the word Tupange or seeing the project logo. In Kisumu, the interpersonal, or mid-media interventions were recalled by a majority of respondents; almost 80 percent of women in Kisumu recall seeing a Tupange caravan-road show. Further, almost a quarter of all women reported that they participated in a community meeting where Tupange was represented.

## Service delivery point survey

### Facility service statistics

Overall, the provision and availability of contraceptive methods increased and the occurrence of stock-outs decreased during the one year time period. Increases were seen in quality assurance measures and aspects of facility infrastructure, most notably the availability of sealed implant packs and sterile gloves.

### Quality of health care services and client satisfaction

Information on the quality of family planning service delivery at baseline and mid-term came from interviews with exiting FP clients as well as FP service providers. Aspects of quality measured by these two data collection instruments included choice of methods, information given to clients, interpersonal relations, provider competence, and follow-up mechanisms. According to clients, providers at mid-term offered more information on different FP methods and inquired more frequently about the client's method of choice. Providers also appeared to do a better job of explaining correct method use and possible side effects of the client's chosen method. According to provider reports, however, fewer providers explain to clients how to use their preferred method and there was a drop in the percent of providers that offer clients information on warning signs. Multiple indicators on client satisfaction, reported by clients, suggest that the majority of FP clients at both time periods were satisfied with the services they received.

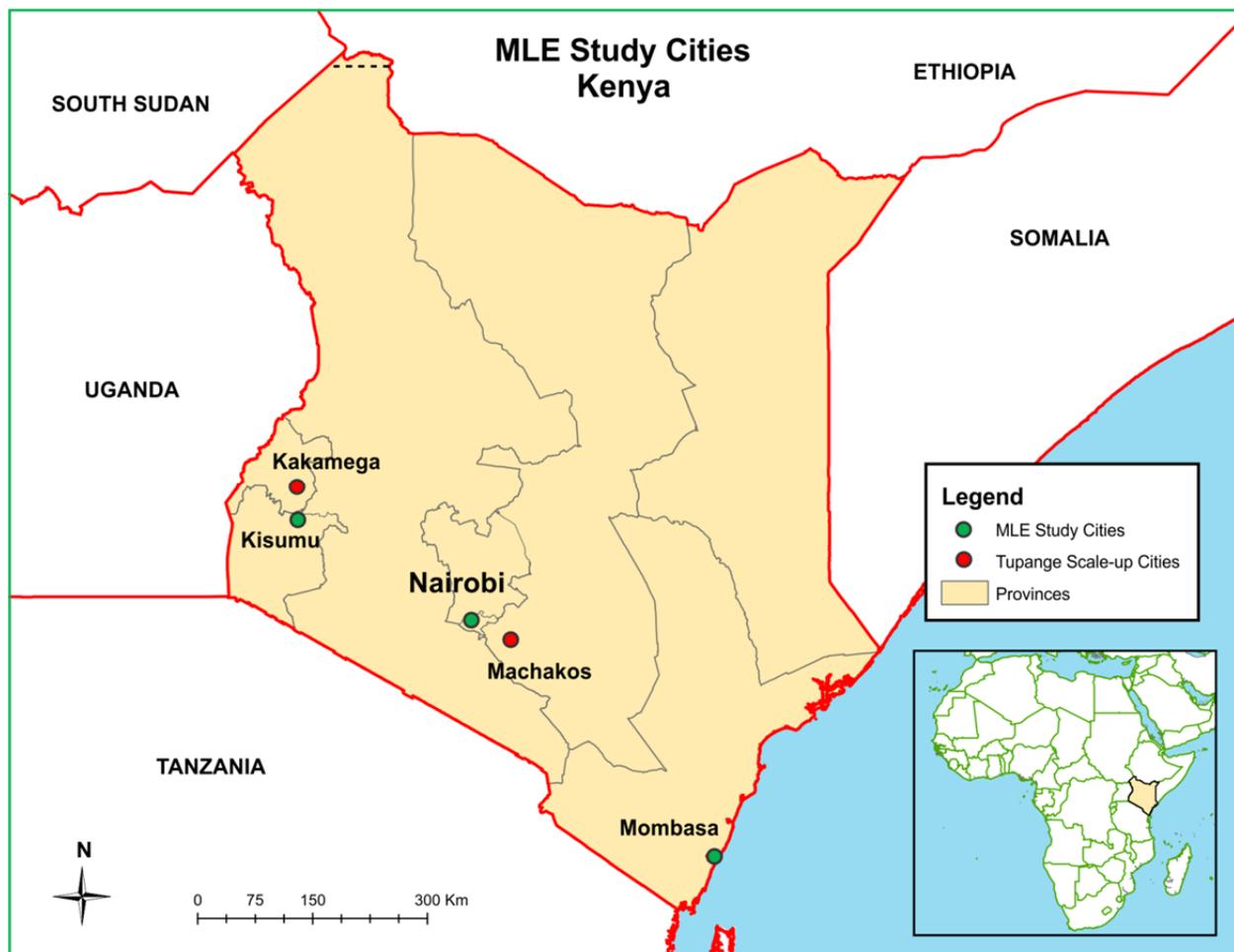
### Exposure to FP messages among exit interview clients

The majority of clients interviewed reported exposure to FP messages at both baseline and mid-term. The most common sources of FP messages included radio, television, clinics, community outreach events, and friends and neighbors. The biggest increases in sources of FP messages between baseline and mid-term were seen in community outreach events, nurses and midwives, and friends and neighbors.

## Chapter 1. Background

The Urban Reproductive Health (RH) Initiative is a six year, multi-country effort by the Bill & Melinda Gates Foundation (BMGF) to reduce the incidence of maternal and infant mortality and unintended pregnancy in the developing world. The Urban RH Initiative addresses these issues by implementing programs to increase the use of modern contraception among urban women in selected countries (Uttar Pradesh, India; Nigeria; Kenya; and Senegal) specifically focusing on the urban poor. In Kenya, the initiative is being implemented by a consortium known as Tupange (“let’s plan” in Kiswahili), led by Jhpiego. The goal of Tupange is to increase the use of modern contraception in five urban centers in Kenya: Nairobi, Mombasa, Kisumu, Machakos and Kakamega (see map).

Family planning (FP) has been proven to save the lives of women and children, especially in countries burdened with high rates of maternal and infant mortality (Cleland 2006). In Kenya, less than 40 percent of all women of reproductive age are currently using a modern contraceptive method (PRB 2012). Low prevalence of contraceptive use contributes to the estimated 530 maternal deaths that occur in Kenya for every 100,000 live births (PRB 2012). Kenya’s National Population Policy calls for the expansion and improvement of quality and availability of family planning services for both men and women; improvements in knowledge and availability of contraceptive services may improve the ability of couples in Kenya to safely determine the number and spacing of their children (NCPD 2012, KNBS and ICF Macro, 2010).



The objectives of Tupange are:

- Develop cost-effective interventions for integrating quality family planning (FP) with maternal and newborn health, HIV/AIDS, postpartum and post-abortion care programs;
- Improve the quality of FP services for the urban poor with emphasis on high volume clinical settings;
- Test novel public private partnerships and innovative private sector approaches to increase access to and use of FP by the urban poor in the private sector;
- Develop interventions for creating demand for and sustaining use of contraceptives among marginalized urban populations;
- Create a supportive policy environment for ensuring access to FP supplies and services for the urban poor through increased funding and financial mechanisms.

### **Measurement, Learning & Evaluation Project**

In order to effectively evaluate the impact of Tupange, as well as the initiatives in the other three countries, BMGF also funded the Measurement, Learning & Evaluation (MLE) project. MLE is a six year program led by the Carolina Population Center at the University of North Carolina at Chapel Hill, to provide evidence and promote evidence-based decision-making in the design of integrated family planning and reproductive health (FP/RH) interventions for the Urban RH Initiative using rigorous and state-of-the-art methods (Guilkey 2009). MLE uses a quasi-experimental study design using a longitudinal sample of women, along with facility surveys in each country.

#### **Baseline survey**

The baseline household survey in Kenya was conducted in 2010 and consisted of individual and household interviews of women and men of reproductive age in Nairobi, Mombasa and Kisumu, and of women and households only in Machakos and Kakamega (MLE, Tupange and KNBS, 2011). Data collection lasted from August 2010 through December 2010. All women ages 15-49, in a representative sample of households in the five cities, were eligible for interview. All men ages 15-59 in Nairobi, Mombasa and Kisumu were also eligible for interview. In total, 8,932 women and 2,503 men were successfully interviewed at baseline. The head of each selected household was administered a questionnaire measuring household characteristics and assets. Individuals were administered a questionnaire focusing on RH and FP. In addition to the household survey, a health service delivery point (SDP) survey was conducted between August and October 2011. This survey consisted of a facility audit, provider interviews, client exit interviews and a pharmacy survey in 279 facilities and 223 pharmacies.

#### **Mid-term survey**

The implementation of the mid-term survey in Kenya began in August 2012. The baseline questionnaire was adapted to provide programmatically relevant data for Tupange to make mid-course corrections. All female respondents from baseline were eligible for interview at mid-term in Nairobi, Mombasa and Kisumu. In Machakos and Kakamega, women were located and interviewers updated respondents' personal contact information in order to be able to locate them in two years for the endline survey. A new cross-sectional sample of men was selected for interview in Mombasa. Only Mombasa was selected for the mid-term men's survey because of the perception that men in Mombasa are more involved in decision-making related to FP issues compared to men in other cities. A facility survey was implemented in 15 facilities in Kisumu; Tupange will use their monitoring data from facilities in the other study cities to inform their mid-course corrections.

## Chapter 2. Methods

At mid-term, all women that participated in the baseline household survey were tracked to confirm current place of residence. Household surveys were conducted among women selected for interview at mid-term in the three study cities and among a new cross-section of men in Mombasa. A short diffusion questionnaire was administered among women in Kakamega. Survey tools were translated and pre-tested in the field prior to the main survey fieldwork. The household survey tools for women were translated into Swahili and Luo. The tools for the men's survey were translated into Swahili.

The mid-term facility survey was carried out in a subset of 15 strategic facilities in Kisumu where Tupange was working. These facilities were also surveyed at baseline. The baseline instruments were repeated for the mid-term survey. The exit interview questionnaire was administered in Luo; the facility audit and provider survey were administered in English.

Sample weights for longitudinal women respondents at mid-term were based on the woman's probability of selection at baseline. Mid-term sample weights were then adjusted for selective attrition and non-response associated with observed characteristics such as marital status, wealth quintile, age, education, religion, ethnic group, baseline contraceptive use, financial holdings, whether she reads newspapers and city of residence at baseline. All estimates presented in this report are weighted.

### Women

#### *Tracking of longitudinal respondents*

The first stage of mid-term fieldwork consisted of revisits to all households of women that were interviewed at baseline. An external research agency, the African Institute for Health and Development (AIHD) was contracted to lead the tracking fieldwork, with supervision from MLE. Tracking teams first visited the households where respondents were interviewed at the time of the baseline survey. Households and female respondents that had moved nearby were traced to their new residence by local tracking teams if the new residence was nearby or within the same study city. If the new residence was in another study city, the respondent was tracked by the teams on the ground in that city. Respondents that had moved outside the five study cities were not tracked further. Some respondents could not be found during the tracking fieldwork period, and were not interviewed at mid-term.

#### *Household and individual surveys*

All women interviewed at baseline in Nairobi, Kisumu and Mombasa were eligible for re-interview at mid-term. In Kakamega, a subsample of women interviewed at baseline were eligible for a short program diffusion questionnaire at mid-term, though the results from this diffusion survey are not presented in this report. In Machakos, all women interviewed at baseline were tracked at mid-term to confirm their current place of residence, but they were not interviewed. As was done at baseline, MLE worked with the Kenya National Bureau of Statistics (KNBS) to conduct the household and individual interviews of women and men.

#### *Household questionnaire*

A household survey was administered in all households of longitudinal respondents located at mid-term. The household survey included a listing of all usual residents and visitors to the household the previous night. Characteristics of all listed household members were collected, including age, sex, education and relationship to the head of household. Information on land tenure, household assets, utilities and housing characteristics was collected among all households where longitudinal respondents lived at mid-term.

***Woman's questionnaire***

The individual woman's survey was administered to all longitudinal respondents located at mid-term in Nairobi, Mombasa and Kisumu. The woman's questionnaire contained the following sections: background characteristics, reproduction, birth history since January 2010, contraception, maternal and child health, sexual activity and marriage, fertility preferences, spousal and interpersonal communication, migration history, a contraceptive calendar and follow-up contacts. Additionally, the mid-term survey contained a series of questions to capture women's exposure to specific program activities. In order to evaluate exposure to Tupange demand generation and behavior change communications, the media module measured respondents' exposure to Tupange-specific media interventions.

**Men**

In Mombasa, a new cross-section of men was selected for interview at mid-term. All 76 primary sampling units (or clusters), which were selected for the baseline survey, were selected for inclusion at mid-term. These 76 clusters were relisted in August 2012 prior to the main survey fieldwork. From this new listing, 1,200 households were selected; all men between the ages of 15-59 in all selected households were eligible for the mid-term men's survey.

***Household questionnaire***

In Mombasa, a household survey was conducted in households selected for the men's survey; upon completion of the household survey, individual surveys were conducted with all eligible men. The household questionnaire was identical to the household questionnaire in the woman's longitudinal survey, consisting of a listing of all usual residents and visitors to the household the night before, characteristics of the household members including age, sex, education and relationship to the head of household, land tenure and assets.

***Man's questionnaire***

All men between the ages of 15-59 in the selected households were eligible for the individual survey in Mombasa. The men's survey included questions on the following: background characteristics, reproduction, sexual activity and marriage, fertility preferences, spousal and interpersonal communication, gender inequity measures, media exposure and migration history. As in the women's survey, the men's survey contained a series of questions to capture exposure to specific program activities. The media module measured men's exposure to Tupange-specific media interventions.

**Service delivery point surveys**

Facility-level data were collected at 15 public and private health care facilities in Kisumu. A facility audit inventory of supplies and equipment and collected information on record-keeping and management. The audit was completed with the assistance of the facility-in-charge staff member. A questionnaire for interviewing FP clients as they exited the facility allowed assessment of the client's viewpoint of the service delivery setting. Questionnaires were completed by a female interviewer to ensure the comfort of the client. A questionnaire for interviewing service providers collected information from providers on training, supervision and attitudes about their work environment. To the extent possible, all interviews were conducted in private to protect the confidentiality of the client and provider respondents.

**Ethical Review**

All procedures, consent forms and survey tools used for the household and facility survey were approved by the Ethical Review Committee at the Kenya Medical Research Institute as well as the Institutional Review Board at the University of North Carolina at Chapel Hill.

## Chapter 3. Response rates and background characteristics

### Response Rates

The results of the individual longitudinal survey are presented in Table 3.1. All women who were interviewed at baseline in Nairobi, Mombasa and Kisumu were eligible for interview at mid-term, and were tracked at mid-term. The first set of columns in Table 3.1 detail the results of the tracking process. Overall, tracking teams led by AIHD found 71 percent of the respondents. Approximately 7 percent of baseline respondents had relocated to non-study cities at mid-term, and were therefore not eligible for interview. The remaining 22 percent were not found, and no further information could be obtained about their whereabouts through the tracking process.

**Table 3.1. Results of the women's longitudinal survey**

Number of female longitudinal respondents and response rates. Kenya, 2012.

	Tracking				Main survey among full panel					Main survey among those found			
	Number of eligible women at mid-term	Percent found within study cities	Percent moved outside of study cities	Percent not found	Total	Percent with completed interviews	Number of women interviewed at mid-term	Number of eligible women found during tracking	Percent with completed interviews (response rate)	Percent refused	Percent died	Percent not interviewed*	Total
Nairobi	2,676	66.4	6.2	27.3	100.0	49.8	1,333	1,778	75.0	5.2	1.1	18.7	100.0
Mombasa	1,460	78.4	8.4	13.3	100.0	63.9	933	1,144	81.6	0.4	0.9	17.1	100.0
Kisumu	1,583	71.6	7.3	21.2	100.0	59.4	941	1,133	83.1	1.2	1.9	14.0	100.0
Total	5,719	70.9	7.1	22.0	100.0	56.1	3,207	4,055	79.1	2.7	1.3	16.9	100.0

\*Women not interviewed includes those women found during tracking but unavailable at the time of interview, and a small number of women (n=118) that were interviewed but excluded because of inconsistencies in background characteristics between the baseline and mid-term surveys.

The second part of table 3.1 details the results of the second stage of the mid-term survey. Teams from KNBS took the tracking information from AIHD and returned to all located households to interview the women. Overall, KNBS teams interviewed 56 percent of women eligible for the mid-term survey who had been interviewed at baseline. Around 2 percent of women found at tracking refused to participate, and another 1 percent had died since baseline. Of those women found during tracking at mid-term, 75 percent in Nairobi, 82 percent in Mombasa and 83 percent in Kisumu were successfully interviewed. Women not interviewed included those women not found during mid-term tracking, women that were found during tracking but unavailable at the time of interview and a small number of women (n=118) that were interviewed but excluded because of inconsistencies in background characteristics between the baseline and mid-term surveys.

**Table 3.2. Results of the men's cross-sectional survey**

Number of male cross-sectional respondents and response rates. Kenya, 2012.

	Main survey					Number of men interviewed at mid-term
	Response rate	Percent refused	Not at home	Percent not interviewed*	Total	
Mombasa	73.8	0.6	16.8	8.8	100.0	696

\* Men not interviewed include those that were incapacitated or had partially completed questionnaires.

The results from the cross-sectional survey of men in Mombasa are presented in Table 3.2. All men aged 15-59 from the selected households were eligible for interview. Field teams interviewed 74 percent of eligible men. Of all men eligible for the survey, 17 percent were not at home, and therefore not interviewed, despite at least three visits from the survey teams. Men not interviewed include those men that were incapacitated or had partially completed questionnaires.

### **Background characteristics of women respondents**

The percent distribution of women and men interviewed at mid-term by age group, education, religion, wealth index and marital status are presented in Tables 3.3 and 3.4.

Age distribution was largely similar across the three cities. Almost 25 percent of women at mid-term were between the ages of 20-24 across the three cities. In Nairobi and Kisumu, approximately one third of women were between the ages of 25-29 at mid-term, whereas in Mombasa, about 22 percent of women were between 25-29.

Mombasa had the largest percentage of women with no education at about 8 percent, followed by Kisumu (about 2 percent) and Nairobi (about 2 percent). Nairobi, at 58 percent, had the highest percentage of women with secondary education and above.

Questions on religious affiliation were not asked at mid-term; Table 3.3 displays reported religion at baseline. The religious composition of the sample varied by city; Nairobi and Kisumu had a roughly similar distribution of Protestants / other Christians and Catholics (approximately 70 percent compared to 20 percent, respectively). Mombasa's Muslim population, at 27 percent, was larger than that of the other cities.

Wealth indices were constructed using the household assets and characteristics collected during the household interview, based on the methods adapted and validated by Filmer and Pritchett (2001). Principal components analysis was employed to generate a factor score for each household. The score were then divided into quintiles; the lowest-rank corresponded to the poorest households and the highest-rank to the richest. Women were grouped into one of the five categories by the rank of their household.

The distribution of women by marital status was consistent across all cities. The percentage of women that had never married in Nairobi was slightly higher (28 percent) compared to Kisumu (22 percent).

Among men in Mombasa, 27 percent of respondents were in the two youngest age groups (15-19 and 20-24). Almost 60 percent of men in Mombasa had achieved secondary education or higher, compared to just under 50 percent of women in that city from the longitudinal sample. The wealth index rankings for men were calculated from the men's household survey using the same methodology as described above for women. About 35 percent of men interviewed had never been married; about 60 percent were married or in union at the time of the survey.

**Table 3.3. Women's background characteristics**

Percent distribution of women by age group, education, religion wealth and marital status at mid-term. Kenya 2012.

Background characteristic	Women		
	Nairobi	Mombasa	Kisumu
<b>Age group</b>			
15-19	3.8	10.1	8.0
20-24	23.4	22.3	23.5
25-29	29.9	21.8	29.4
30-34	17.8	18.7	17.9
35-39	12.1	11.2	9.0
40-44	7.5	8.9	7.2
45-52	5.4	7.0	5.1
<b>Education</b>			
No education	1.8	7.6	2.4
Primary incomplete	10.9	16.2	19.2
Primary	29.3	27.5	28.1
Secondary and above	58.0	48.7	50.4
Missing	0.2	0.0	0.0
<b>Religion*</b>			
Catholic	25.1	12.3	22.0
Protestant / other Christian	70.1	49.0	71.9
Muslim	3.4	37.2	4.5
No religion / other	1.4	1.5	1.2
Missing	0.0	0.0	0.4
<b>Wealth index</b>			
Poorest	20.3	20.6	21.2
Poor	19.0	19.9	19.8
Middle	20.0	22.6	19.1
Rich	21.5	18.2	20.2
Richest	19.2	18.7	19.8
<b>Marital status</b>			
Never married	27.8	25.9	21.6
Married / living together	60.6	61.7	65.1
Separated / divorced	8.3	9.5	5.9
Widowed	3.4	2.9	7.4
Total number of women	1,333	933	941

\*Reported at baseline

Note: The small number of respondents with missing responses are not included in the indicator calculation

**Table 3.4. Men's background characteristics**

Percent distribution of men by age group, education, religion, and wealth at midterm. Kenya, 2012.

Background characteristic	Men
	Mombasa
<b>Age group</b>	
15-19	13.6
20-24	13.9
25-29	18.7
30-34	15.6
35-39	11.3
40-44	10.6
45-49	5.7
50-54	5.5
55-59	5.1
<b>Education</b>	
No education	2.2
Primary incomplete	13.4
Primary	26.4
Secondary and above	58.0
<b>Religion</b>	
Catholic	15.2
Protestant/other Christian	49.5
Muslim	33.5
No religion	0.4
Other	1.4
<b>Wealth index</b>	
Poorest	21.3
Poor	22.7
Middle	21.3
Rich	17.7
Richest	17.0
<b>Marital status</b>	
Never married	35.0
Married / living together	60.3
Widowed / separated / divorced	4.7
Total number of men	696

Note: The small number of respondents with missing responses are not included in the indicator calculation

## Chapter 4. Family planning

This chapter presents data from the three study cities on knowledge of FP among women and men, use of FP, unmet need for FP services, common sources of contraceptive services and commodities, as well as perceptions related to the use of long-acting methods and the treatment of FP clients by service providers. This chapter also explores non-users of FP to understand their intention to use FP in the next 12 months and possible reasons for non-use of FP methods. Lastly, this chapter explores switching of contraceptive methods between the baseline and mid-term survey.

### Knowledge of contraceptive methods

Survey participants provided information on their knowledge of the various ways a couple can prevent pregnancy. Respondents were first asked to spontaneously mention all methods known to them. The interviewer then described any method not mentioned spontaneously and probed the respondent for recognition. Information was collected on knowledge of all available modern methods, including female and male sterilization, implants, intrauterine devices (IUDs), injectables, pills, emergency contraception (E-pill), male and female condoms and the lactational amenorrhea method (LAM). Respondents were also asked about the Standard Days Method (SDM) and other traditional methods (periodic abstinence and withdrawal). Results are presented in Tables 4.1 and 4.2, by city and, for both women and men. Baseline data collected in 2010 is compared with the 2012 mid-term data where possible.

**Table 4.1. Women's knowledge of contraception**

Percent distribution of women by knowledge of contraceptive method by type of method and city at baseline and midterm. Kenya 2010, 2012.

Method	Nairobi		Mombasa		Kisumu	
	Baseline	Mid-term	Baseline	Mid-term	Baseline	Mid-term
	Spontaneous or probed knowledge					
Any method	98.1	99.9	98.3	100.0	99.0	99.9
Any modern method	98.1	99.9	98.3	100.0	98.9	99.9
Female Sterilization	63.4	87.9	71.1	79.6	74.8	82.8
Male Sterilization	50.0	68.6	56.7	52.2	52.7	57.9
Implant	81.4	95.4	78.9	91.0	87.0	96.9
IUD	82.8	94.5	78.0	84.3	83.3	90.5
Injectables	95.4	99.2	93.4	98.2	96.5	98.8
Daily Pill	94.9	98.9	94.4	97.4	95.0	98.1
E-pill	57.7	83.4	44.5	66.6	57.6	78.4
Male Condom	96.7	99.7	97.5	99.1	98.4	99.7
Female Condom	87.1	94.0	74.9	81.9	87.8	88.9
LAM / breastfeeding	49.7	70.5	40.2	73.3	46.8	66.1
Standard days / cycle beads	79.2	90.0	78.9	86.5	78.0	80.2
Other traditional methods *	58.3	73.8	63.7	73.4	57.2	63.8

\* Other traditional methods include periodic abstinence and withdrawal

**Table 4.2. Men's knowledge of contraception**

Percent distribution of men by knowledge of contraceptive method by type of contraceptive method in Mombasa at baseline and midterm. Kenya 2010, 2012.

	Mombasa	
	Baseline	Mid-term
	n = 678	n = 696
	Spontaneous or probed knowledge	Spontaneous or probed knowledge
<b>Method</b>		
Any method	99.9	99.6
Any modern method	99.9	99.6
Female Sterilization	82.9	72.7
Male Sterilization	68.9	53.2
Daily Pill	95.2	94.2
IUD	60.2	59.4
Injectables	93.9	93.8
Implants	72.9	67.0
Male Condom	99.9	98.7
Female Condom	96.3	88.2
LAM / breastfeeding	27.3	26.4
E-pill	79.0	68.5
Standard days / cycle beads	91.5	90.4
Other traditional methods*	82.2	78.3

\*Other traditional methods include periodic abstinence and withdrawal

### Women's knowledge of FP methods

Knowledge among women of all methods was generally higher at mid-term, and was nearly universal across all methods and cities. For both men and women, knowledge of most FP methods was high. With the exception of male sterilization in Mombasa, women's knowledge of all contraceptive methods improved in all cities between baseline and mid-term. The largest improvements were in knowledge of some of the long-acting and permanent methods such as female sterilization and implants as well as shorter acting methods like E-pill, LAM and traditional methods.

### Modern methods

All women surveyed at mid-term were aware of at least one modern method of FP. Women were most familiar with certain methods such as implants (91 to 97 percent), injectables (98 to 99 percent), pills (97 to 99 percent), and male condoms (99 to 100 percent). Several other modern methods were slightly less known but still highly recognized including female sterilization (80 to 88 percent), IUD (84 to 95 percent), female condoms (82 to 94 percent), and SDM (80 to 90 percent). Knowledge of E-pill was lower, ranging from 67 percent in Mombasa to 84 percent in Nairobi. Awareness of male sterilization was lowest; only half of women in Mombasa were familiar with this form of contraception. At close to 70 percent, many more women in Nairobi expressed knowledge of male sterilization, yet it was still the least known method in all cities.

## Traditional methods

Although knowledge of traditional methods was less universal than knowledge of modern methods, across all three cities there were large improvements in knowledge of these methods. Knowledge of traditional methods increased 10 to 17 percentage points. Awareness of SDM, which was relatively high in all cities at baseline (approximately 79 percent), increased between 2 to 11 percentage points by mid-term.

## Men's knowledge of FP methods

Knowledge of any FP method was nearly universal among men in Mombasa, with the pill, injectables, condoms (male and female) and SDM ranking highest. The male condom was the most known method among men. Two thirds of respondents were aware of female sterilization, implants, E-pill and other traditional methods. Even after probing by the interviewer, fewer men expressed knowledge of male sterilization or IUD and only one in four men were aware of LAM. Few notable differences were seen between the two cross-sectional samples; there was a 10 to 15 percentage point drop in knowledge of male and female sterilization and a similar drop in knowledge of the E-pill.

## Current use of contraception and method mix

### *Women's current contraceptive use*

Data on current use of modern and traditional FP methods among women in Nairobi, Mombasa and Kisumu were analyzed by wealth quintile and are presented in Table 4.3. Overall use by method type is displayed for all women, irrespective of marital status, as well as for women married or in union. In all three cities, the prevalence of contraceptive use increased, with the largest increase seen in Kisumu where overall use of FP rose from 48 to 61 percent. In Mombasa, where the prevalence of contraceptive use at baseline was lowest, current overall use rose from 34 to 44 percent and in Nairobi, where overall use at baseline was similar to Kisumu, an increase was seen from 48 to 56 percent. In all cities, increases in contraceptive prevalence occurred in both modern and traditional methods. In Nairobi and Mombasa, increases in traditional method use constituted about half of the total gains in overall contraceptive prevalence although use of traditional methods remained much lower (5 to 9 percent among all women) at mid-term compared to modern methods (44 to 61 percent among all women). All cities saw substantial increases in overall use of contraception among married women, from nearly 8 percentage points in Nairobi and Mombasa to 12 percentage points in Kisumu. Current contraceptive use among the urban poor increased in Nairobi and Mombasa by 10 to 22 percentage points. By contrast, in Kisumu increases were more consistent across almost all wealth quintiles. Increases in modern method use of 11 to 22 percentage points occurred across four of the five wealth quintiles in Kisumu.

### Contraceptive method mix

Table 4.4 presents data on contraceptive use by method type.<sup>1</sup> At mid-term, injectables remained the most popular method across all cities and most wealth quintiles, with the exception of women in the richest one or two quintiles who maintained a greater preference for pills or condoms. Between 15 and 19 percent of all women use injectables, with higher percentages in Nairobi and Kisumu compared to Mombasa. Pills and condoms were also popular in all three cities, with use ranging from 4 to 9 percent for pills and 5 to 10 percent for condoms. It also remained true that, across all cities, the women in the richest wealth group were the most likely to use condoms as compared to the other wealth groups. Use of the implant increased in all cities with approximately 6 percent of respondents currently using this method in Nairobi and Mombasa and 16 percent in Kisumu, which represents a three-fold increase from baseline. Of particular note, women in the lowest wealth quintiles in Nairobi and Mombasa saw significant increases in the use of implants; among the poorest quintile in Mombasa, implant use

<sup>1</sup> Statistical significance test results and associated p-values for the differences between CPR and method mix at baseline and mid-term are presented in Appendix 1.

went from 1 percent at baseline to 14 percent at mid-term. In Kisumu, where implant use at baseline was similar to pill use, implant use doubled across all wealth quintiles; among the lowest three quintiles, use reached 20 percent of women surveyed. Modest increases were also seen in the use of sterilization and IUD in all three cities, except in Mombasa where IUD use fell slightly.

**Table 4.3. Current use of contraception**

Percent distribution of women by type of contraceptive method currently used by wealth quintile and city. Kenya 2010, 2012.

	Baseline family planning use				Mid-term family planning use			
	Modern <sup>1</sup>	Traditional <sup>2</sup>	Not using	Total	Modern <sup>1</sup>	Traditional <sup>2</sup>	Not using	Total
<b>Nairobi</b>								
Poorest	35.9	3.8	60.4	100.0	42.7	7.9	49.4	100.0
Poor	43.9	3.3	52.8	100.0	56.8	7.6	35.7	100.0
Middle	52.5	4.3	43.3	100.0	55.8	7.3	36.9	100.0
Rich	43.6	4.4	52.0	100.0	47.5	7.2	45.2	100.0
Richest	40.5	4.5	55.1	100.0	38.9	7.9	53.1	100.0
Overall	43.7	4.1	52.3	100.0	48.3	7.6	44.1	100.0
Overall - in union	58.0	4.9	37.2	100.0	62.0	8.3	29.7	100.0
<b>Mombasa</b>								
Poorest	24.1	4.7	71.2	100.0	42.1	8.2	49.7	100.0
Poor	31.0	3.2	65.8	100.0	34.0	9.7	56.3	100.0
Middle	36.1	5.5	58.4	100.0	33.1	8.7	58.2	100.0
Rich	30.6	3.1	66.3	100.0	31.7	10.7	57.6	100.0
Richest	28.0	5.0	67.0	100.0	29.5	9.4	61.0	100.0
Overall	29.4	4.4	66.3	100.0	34.2	9.3	56.5	100.0
Overall - in union	41.7	6.7	51.7	100.0	44.2	11.4	44.4	100.0
<b>Kisumu</b>								
Poorest	44.3	3.0	52.7	100.0	55.5	2.7	41.8	100.0
Poor	44.9	3.5	51.6	100.0	61.0	1.6	37.4	100.0
Middle	41.8	4.4	53.8	100.0	63.9	5.3	30.8	100.0
Rich	47.6	2.4	50.1	100.0	43.5	7.3	49.1	100.0
Richest	42.7	5.0	52.3	100.0	54.3	8.6	37.1	100.0
Overall	44.4	3.6	52.1	100.0	55.5	5.1	39.4	100.0
Overall - in union	52.3	4.6	43.2	100.0	62.8	5.8	31.5	100.0

1 Modern methods include male/female sterilization, daily pill, IUD, injectables, male condom, female condom, LAM/breastfeeding and E-pill

2 Traditional methods include periodic abstinence, withdrawal, and standard days/safe days/cycle beads

Figure 4.1. Current use of contraception at baseline and mid-term

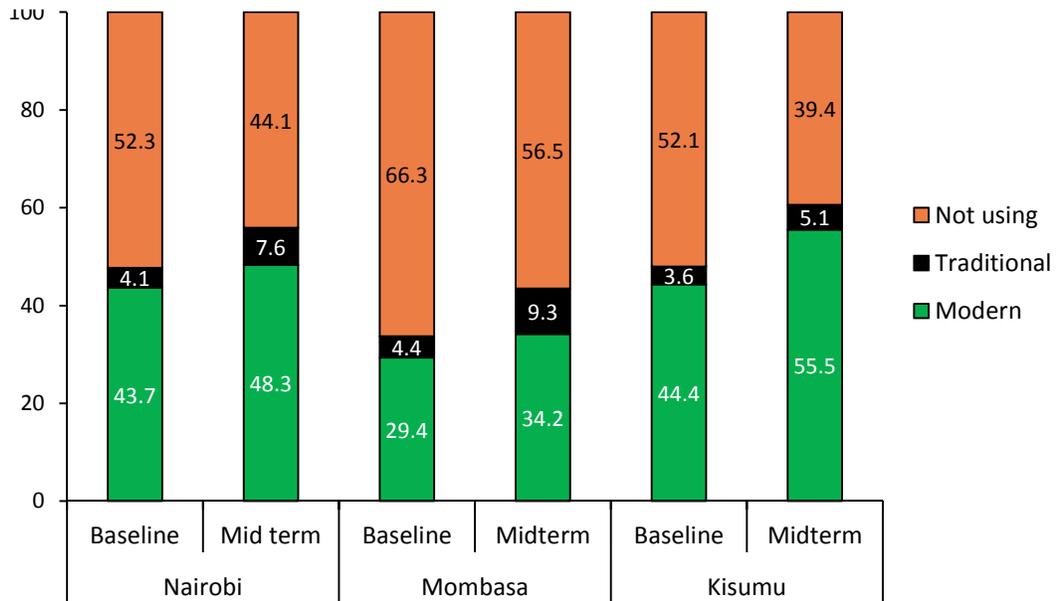
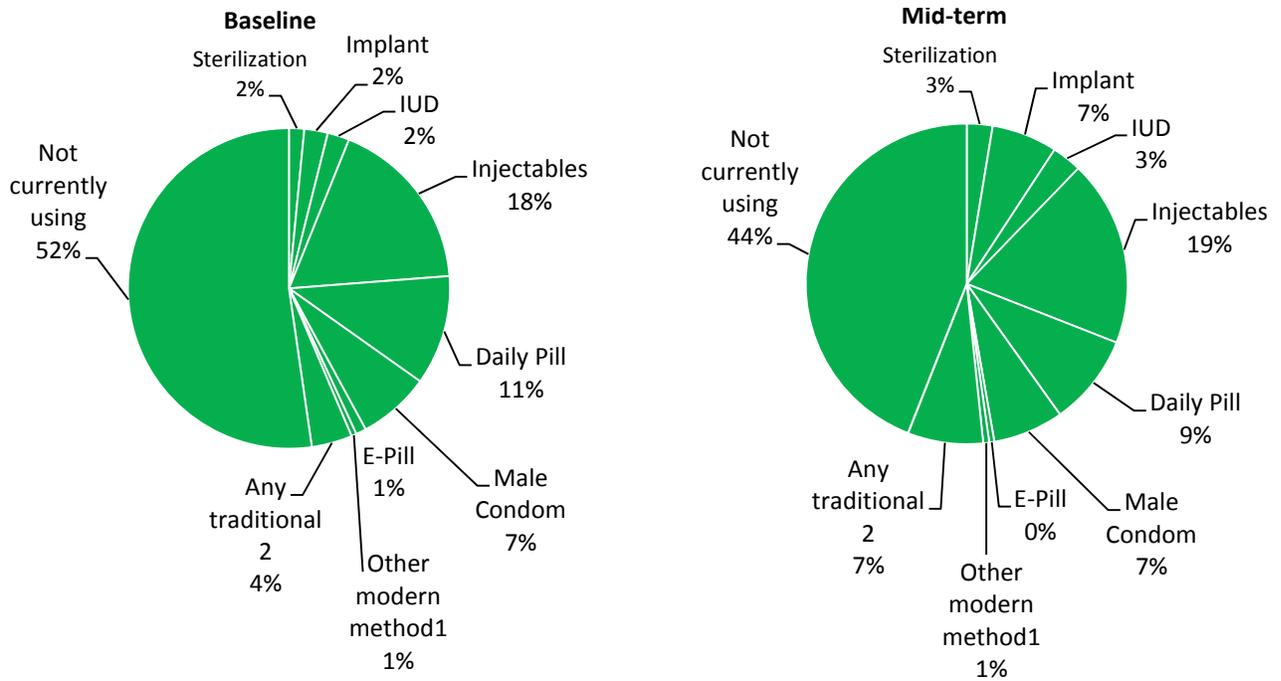


Figure 4.2. Contraceptive method use at baseline and mid-term



**Table 4.4. Contraceptive method use**

Percent distribution of women by contraceptive method currently used, by wealth quintile and city at baseline and mid-term. Kenya 2010, 2012.

	Any method	Any modern method	Modern method								Any traditional <sup>2</sup>	Not currently using	Number of women
			Sterilization	Implant	IUD	Injectables	Daily Pill	Male Condom	E-Pill	Other modern method <sup>1</sup>			
<b>Nairobi</b>													
<b>Baseline</b>													
Poorest	39.6	35.9	1.9	1.0	0.8	21.7	5.5	3.3	1.0	0.5	3.8	60.4	394
Poor	47.2	43.9	1.1	1.0	2.0	25.2	7.3	5.5	0.9	1.0	3.3	52.8	540
Middle	56.7	52.5	1.1	2.5	1.1	21.7	18.4	6.5	0.7	0.5	4.3	43.3	570
Rich	48.0	43.6	0.9	2.4	1.6	17.8	11.1	7.9	1.4	0.6	4.4	52.0	570
Richest	44.9	40.5	2.7	4.2	4.7	5.1	11.2	11.3	1.2	0.1	4.5	55.1	632
Overall	47.7	43.7	1.5	2.4	2.2	17.7	11.1	7.3	1.0	0.5	4.1	52.3	2,705
<b>Mid-term</b>													
Poorest	50.6	42.7	2.0	5.9	1.3	19.1	8.9	5.3	0.0	0.1	7.9	49.4	271
Poor	64.3	56.8	1.6	9.4	1.4	32.7	6.4	4.9	0.4	0.0	7.6	35.7	254
Middle	63.1	55.8	3.5	7.4	3.1	26.2	10.8	4.3	0.0	0.6	7.3	36.9	266
Rich	54.8	47.5	3.3	6.1	3.7	12.9	13.7	5.7	1.4	0.8	7.2	45.2	286
Richest	46.9	38.9	2.5	4.4	5.3	3.5	5.7	15.6	0.6	1.3	7.9	53.1	256
Overall	55.9	48.3	2.6	6.6	3.0	18.8	9.2	7.1	0.5	0.6	7.6	44.1	1,333
<b>Mombasa</b>													
<b>Baseline</b>													
Poorest	28.8	24.1	0.6	1.1	0.3	15.0	3.5	2.5	0.0	1.1	4.7	71.2	345
Poor	34.2	31.0	0.9	1.4	1.8	16.9	4.4	3.9	1.5	0.1	3.2	65.8	236
Middle	41.6	36.1	1.4	1.6	0.0	17.6	9.4	2.6	3.5	0.1	5.5	58.4	235
Rich	33.7	30.6	0.8	1.5	0.0	15.2	8.9	3.6	0.5	0.0	3.1	66.3	294
Richest	33.1	28.0	2.0	3.3	2.9	6.2	6.1	6.6	0.0	1.0	5.0	67.0	356
Overall	33.7	29.4	1.2	1.8	1.1	13.6	6.3	3.9	0.9	0.5	4.4	66.3	1,465
<b>Mid-term</b>													
Poorest	50.3	42.1	0.1	13.7	0.6	19.8	3.9	1.6	0.9	1.5	8.2	49.7	192
Poor	43.7	34.0	2.0	7.5	0.5	20.5	0.6	2.8	0.0	0.1	9.7	56.3	185
Middle	41.8	33.1	2.4	2.8	0.1	15.1	4.4	6.0	0.0	2.3	8.7	58.2	211
Rich	42.4	31.7	1.1	4.9	2.2	14.9	2.9	5.7	0.0	0.1	10.7	57.6	170
Richest	39.0	29.6	2.5	2.8	1.4	3.1	9.0	7.4	0.0	3.3	9.4	61.0	175
Overall	43.5	34.2	1.6	6.4	0.9	14.9	4.1	4.7	0.2	1.5	9.3	56.5	933
<b>Kisumu</b>													
<b>Baseline</b>													
Poorest	47.3	44.3	1.3	4.9	0.8	23.2	5.9	7.2	0.4	0.6	3.0	52.7	431
Poor	48.4	44.9	2.0	5.9	0.3	22.3	4.0	9.1	0.7	0.6	3.5	51.6	335
Middle	46.3	41.8	1.6	2.8	0.5	25.2	4.7	7.0	0.0	0.0	4.4	53.8	245
Rich	49.9	47.6	1.9	4.1	1.2	22.0	6.4	10.3	1.3	0.4	2.4	50.1	301
Richest	47.7	42.7	3.5	4.7	3.2	10.7	3.8	15.1	1.1	0.6	5.0	52.3	291
Overall	47.9	44.4	2.0	4.6	1.1	20.8	5.0	9.6	0.7	0.5	3.6	52.1	1,603
<b>Mid-term</b>													
Poorest	58.2	55.5	2.0	19.8	0.8	23.3	3.8	5.6	0.2	0.0	2.7	41.8	200
Poor	62.6	61.0	4.1	20.5	0.5	19.0	6.2	9.1	0.0	1.5	1.6	37.4	186
Middle	69.2	63.9	1.7	19.5	1.9	29.9	3.8	5.0	0.0	1.9	5.3	30.8	179
Rich	50.9	43.5	2.2	8.6	0.5	11.5	6.7	14.1	0.0	0.0	7.3	49.1	190
Richest	62.9	54.3	6.1	9.8	3.3	11.8	4.5	16.2	1.9	0.7	8.6	37.1	186
Overall	60.6	55.5	3.2	15.7	1.4	19.1	5.0	10.0	0.4	0.8	5.1	39.4	941

1 Other modern methods include female condom and LAM/breastfeeding

2 Traditional methods include periodic abstinence, withdrawal, and standard days/safe days/cycle beads

## Unmet Need

Multiple indicators from the woman's questionnaire were used to determine the percent of fecund women who prefer to space or limit births but are not using any method of contraception. Currently pregnant or postpartum women were included in the calculation of unmet need if they report that their last pregnancy was mistimed or unwanted. An unmet need to space births refers to those women not using FP who responded that they wished to delay future pregnancy, while an unmet need to limit births refers to those women not using FP who responded that they wished to avoid any future pregnancy.

As seen in Table 4.5, at baseline, 16 percent of women in Nairobi had an unmet need for FP either to space or limit births. This percent was slightly higher in Kisumu (19 percent) and Mombasa (20 percent). By mid-term, unmet need among women in Nairobi had dropped to 11 percent and in Kisumu and Mombasa had decreased to 16 percent. Overall, total unmet need was 2 to 4 percentage points lower at mid-term in each city. In both Mombasa and Kisumu, changes in unmet need appeared greater among lower wealth quintiles. At baseline in Nairobi and Kisumu, a greater percent of women across nearly all wealth quintiles had an unmet need for spacing

**Table 4.5. Unmet need for family planning**

Percent distribution of currently married women with unmet need and met need (no unmet need), by wealth quintile and city, at baseline and mid-term. Kenya 2010, 2012

	Baseline					Mid-term			
	Unmet need for spacing	Unmet need for limiting	No unmet need	Missing	Total	Unmet need for spacing	Unmet need for limiting	No unmet need	Total
<b>Nairobi</b>									
Poorest	10.1	12.0	78.0	0.0	100.0	8.5	17.1	74.4	100.0
Poor	12.6	8.0	79.4	0.0	100.0	4.8	2.1	93.2	100.0
Middle	7.6	5.0	87.0	0.5	100.0	6.3	2.8	90.9	100.0
Rich	7.7	5.2	87.1	0.0	100.0	1.5	3.4	95.1	100.0
Richest	9.5	3.2	87.4	0.0	100.0	8.2	5.9	85.8	100.0
Overall	9.4	6.5	84.0	0.1	100.0	5.6	5.8	88.6	100.0
<b>Mombasa</b>									
Poorest	14.0	11.7	74.3	0.0	100.0	9.2	5.3	85.5	100.0
Poor	11.0	10.7	78.3	0.0	100.0	11.1	6.7	82.2	100.0
Middle	5.8	12.6	81.6	0.0	100.0	7.5	7.2	85.3	100.0
Rich	5.1	7.5	86.5	0.9	100.0	13.1	5.3	81.6	100.0
Richest	7.6	13.8	78.7	0.0	100.0	5.3	12.0	82.7	100.0
Overall	8.5	11.3	80.0	0.2	100.0	9.3	7.2	83.5	100.0
<b>Kisumu</b>									
Poorest	14.0	9.6	76.4	0.0	100.0	13.7	5.8	80.5	100.0
Poor	10.4	9.0	79.7	0.2	100.0	5.0	12.9	82.2	100.0
Middle	9.5	9.3	81.2	0.0	100.0	9.0	5.2	85.8	100.0
Rich	9.0	8.3	82.7	0.0	100.0	7.3	13.6	79.1	100.0
Richest	6.2	5.9	87.9	0.0	100.0	4.5	4.9	90.6	100.0
Overall	10.0	8.5	81.3	0.2	100.0	8.1	8.4	83.5	100.0

\*Unmet need for spacing includes pregnant women whose pregnancy was mistimed; and fecund women who are not pregnant, who are not using any method of family planning, and say they want to wait 2 or more years for their next birth. Unmet need for limiting refers to pregnant women whose pregnancy was unwanted; and fecund women who are not pregnant, who are not using any method of family planning, and who want no more children. Excluded from the unmet need category are pregnant women who became pregnant while using a method.

births, compared to the need to limit births. In Mombasa, women in the upper wealth quintiles had a greater unmet need to limit rather than space births at baseline. At mid-term there was no discernible pattern across quintiles of wealth with respect to the need to space versus limit births. Overall, the percent of women with an unmet need for spacing at mid-term was approximately the same as those with an unmet need for limiting births in both Nairobi and Kisumu; a slightly greater percent of women in Mombasa had an unmet need for spacing compared to limiting, which was a reversal since baseline.

### Source of current modern contraceptive method

Current users of modern contraception reported the last source of their current method; responses are shown in Table 4.6 and are categorized as public facilities, private facilities, pharmacies/chemists or other (including mobile clinic, kiosk/shop/market or TBA/CHW). Private facilities were the most popular source of long-acting methods like the implant and IUD at baseline, providing 70 percent of all implants among participants in Mombasa and nearly half of implants in Nairobi and Kisumu. At mid-term, however, Mombasa and Kisumu both saw substantial increases in the percent of clients receiving implants at public facilities. Similarly, the percent of clients receiving IUDs at public facilities increased from 38 to 54 percent in Kisumu and 36 to 43 percent in Nairobi. Overall this suggests a trend towards greater use of public facilities for obtainment of longer-acting methods. Patterns were less clear among shorter acting methods like injectables and pills. For these methods, the most popular source varies by city and did not change substantially between baseline and mid-term. Condoms were primarily obtained at baseline and mid-term from pharmacies or other locations. Other sources included shops, kiosks, worksite clinics, and voluntary counseling and testing centers.

**Table 4.6. Source of modern contraceptive method**

Percent distribution of women using a modern method by source of modern contraceptive method by city, at baseline and mid-term. Kenya 2010, 2012.

Source	Baseline method source					Mid-term method source				
	Implant	IUD	Injectables	Daily pill	Condom	Implant	IUD	Injectables	Daily pill	Condom
<b>Nairobi</b>	n = 64	n = 59	n = 480	n = 300	n = 196	n = 89	n = 39	n = 250	n = 123	n = 94
Public	48.5	35.7	47.8	29.8	10.0	39.5	42.6	54.5	28.1	9.8
Private hospital / clinic / doctor	46.5	64.3	43.3	24.2	7.2	56.6	49.6	36.7	13.6	5.6
Pharmacy / chemist	1.7	0.0	7.7	44.7	47.7	0.0	0.0	8.6	57.7	52.4
Other*	3.2	0.0	0.6	1.2	31.4	3.9	7.8	0.1	0.6	28.1
Missing/Don't know	0.0	0.0	0.5	0.1	3.7	0.0	0.0	0.0	0.0	4.2
<b>Mombasa</b>	n = 27	n = 16	n = 199	n = 92	n = 58	n = 59	n = 8	n = 138	n = 38	n = 44
Public	29.9	43.3	45.8	25.5	5.4	55.8	37.1	42.1	24.9	8.8
Private hospital / clinic / doctor	70.1	56.7	51.3	40.8	8.5	28.8	62.9	51.5	30.9	7.1
Pharmacy / chemist	0.0	0.0	2.3	31.8	36.3	0.0	0.0	2.5	36.4	48.8
Other*	0.0	0.0	0.0	1.8	46.1	15.4	0.0	3.9	7.9	35.3
Missing/Don't know	0.0	0.0	0.6	0.0	3.6	0.0	0.0	0.0	0.0	0.0
<b>Kisumu</b>	n = 73	n = 18	n = 333	n = 81	n = 154	n = 147	n = 13	n = 180	n = 47	n = 94
Public	27.5	38.2	73.6	60.4	19.5	41.6	53.8	71.8	43.7	13.5
Private hospital / clinic / doctor	46.2	61.8	21.5	12.3	7.6	41.0	46.2	24.9	28.8	3.9
Pharmacy / chemist	0.0	0.0	3.8	25.6	29.8	0.0	0.0	3.1	27.5	22.3
Other*	25.4	0.0	1.0	1.7	34.7	17.5	0.0	0.2	0.0	58.9
Missing/Don't know	0.9	0.0	0.0	0.0	8.5	0	0.0	0.0	0.0	1.5

\*Other includes mobile clinics, kiosk / shop / market, TBA / CHW

## Changes in FP method source

Table 4.7 presents data on changes in the sources of injectables and pills among women who used these methods at baseline and mid-term. The indicators in this table are based on the matched subsample of baseline women that were interviewed again at mid-term. Most pill users who were getting their pills from public sources, pharmacies or chemists did not change their method source between the two time periods. Among the small number of women using the pill at baseline and mid-term, 82 percent of pill users at baseline still received their pills from a public source at mid-term. About 76 percent of pill users at baseline that obtained their pills from a pharmacy got their pills from a pharmacy at mid-term. Only 26 percent of pill users that obtained their pills from a private source at baseline remained with a private supplier at mid-term. Among the small number of women using injectables at both baseline and mid-term, some changes were reported in the source of their method. Only about 31 percent of injectable users at baseline that obtained their method from a pharmacy or chemist still received injectables from a pharmacy or chemist at mid-term. Most injectable users at baseline that used a pharmacy or chemist at baseline switched to a private source at mid-term (54 percent). About 35 percent of those that obtained their injectables from a public source at baseline changed to a private source at mid-term. A majority of women (69 percent) that obtained their injectables from a private facility at baseline were still using a private facility at mid-term. About 62 percent of women that obtained their injectables from a public source at baseline were still using a public source at mid-term..

**Table 4.7. Change in daily pill and injectable use**

Percent distribution of women using daily pills and injectables at baseline and mid-term that switched sources between 2010 and 2012. Kenya 2010, 2012.

Baseline <b>daily pill</b> source	Mid-term <b>daily pill</b> source					Total	Number of women
	Public	Private hospital / clinic / doctor	Pharmacy / chemist	Other*	Missing/ don't know		
Public	82.0	5.2	12.8	0.0	0.0	100.0	27
Private hospital / clinic / doctor	31.9	26.1	35.8	6.2	0.0	100.0	35
Pharmacy / chemist	4.1	19.6	76.2	0.0	0.0	100.0	39
Other*	0.0	0.0	0.0	0.0	0.0	100.0	0
Missing / don't know	0.0	100.0	0.0	0.0	0.0	100.0	2
Total	34.0	19.8	44.1	2.1	0.0	100.0	103

Baseline <b>injectable</b> source	Mid-term <b>injectable</b> source					Total	Number of women
	Public	Private hospital / clinic / doctor	Pharmacy / chemist	Other*	Missing/ don't know		
Public	61.9	34.8	2.9	0.5	0.0	100.0	126
Private hospital / clinic / doctor	28.6	68.3	3.0	0.1	0.0	100.0	106
Pharmacy / chemist	14.6	54.9	30.5	0.0	0.0	100.0	11
Other*	0.0	100.0	0.0	0.0	0.0	100.0	1
Missing / don't know	0.0	0.0	0.0	0.0	0.0	100.0	0
Total	45.1	50.4	4.2	0.3	0.0	100.0	244

Note: Baseline estimates include all women successfully interviewed at baseline and mid-term

\*Other includes mobile clinics, kiosk / shop / market, TBA / CHW

## Future intention to use contraception and reasons for non-use

### Contraceptive intentions

At both baseline and mid-term, women who were not currently using contraception were asked whether they intend to use an FP method to delay or avoid pregnancy during the next 12 months; results are presented in Table 4.8. At baseline, approximately 20 percent of women in Mombasa and 30 to 34 percent respectively in Nairobi

and Kisumu reported an intention to use FP in the next 12 months. In contrast, by mid-term 32 percent of women in Mombasa and approximately 40 percent of women in Nairobi and Kisumu intended to use FP within the next year, revealing a substantial increase in intention to use FP among this panel of women. The majority of women (55 to 68 percent) did not know their future contraceptive intentions at baseline while far fewer women (4 to 12 percent) were undecided at mid-term. At mid-term, half of the women in each city still did not plan to use contraception in the next year. Among men (Table 4.9), approximately 18 percent of men who were not using a method at both baseline and mid-term intended to use FP within the next 12 months. At mid-term, two-thirds of men did not intend to use FP in the next year (up from 55 percent at baseline) and 15 percent were undecided.

**Table 4.8. Future intention to use contraception among women**

Percent distribution of women not currently using contraception, by their intention to use in the future, by city at baseline and mid-term. Kenya 2010, 2012.

	Baseline future intention to use FP					Mid-term future intention to use FP				
	Intends to use FP in the next 12 months	Does not intend to use in next 12 months	Does not know	Missing	Total number of women not using	Intends to use FP in the next 12 months	Does not intend to use in next 12 months	Does not know	Missing	Total number of women not using
<b>Nairobi</b>	29.6	60.6	8.8	1.0	1,322	40.2	47.5	11.8	0.5	572
<b>Mombasa</b>	18.4	67.9	13.5	0.3	907	32.3	57.8	9.0	0.9	500
<b>Kisumu</b>	34.4	54.7	10.3	0.6	778	42.2	52.7	4.2	0.9	348

**Table 4.9. Future intention to use contraception among men**

Percent distribution of men not currently using contraception, by their intention to use in the future, by city at baseline and mid-term. Kenya 2010, 2012.

		Men				Total number of men not using
		Future intention to use contraception				
		Intends to use FP in the next 12 months	Does not intend to use in next 12 months	Does not know	Missing	
<b>Baseline</b>	Mombasa	17.6	55.0	27.4	0.0	261
<b>Mid-term</b>	Mombasa	18.7	66.0	15.3	0.0	309

### Reasons for non-use of contraception

Women not currently using any method of contraception were asked to share their reasons for non-use and these results are shown in Table 4.10. The most common reasons for non-use at both baseline and mid-term were fertility-related. Close to half of non-users in each city at baseline and mid-term reported they were not using FP due to infrequent or no sex or because they were not yet married or without a partner. Opposition to use decreased overall although a slight increase was seen in religious opposition in Nairobi and Mombasa and in personal opposition in Kisumu. Lack of knowledge was rarely mentioned by non-users at mid-term. Regarding method-related reasons for non-use, between 5 and 15 percent of women not currently using FP remained concerned about method side effects across all three cities. Like women, men most commonly reported non-use due to infrequent or no sex or because they were not yet married or without a partner, and this percentage rose from 39 to 48 between baseline and mid-term (see Table 4.11). Many more non-using men at mid-term reported personal opposition, compared to non-using men at baseline.

**Table 4.10. Reasons for non-use of contraception among women**

Percent of women by reasons for non-use of contraception, by city at baseline and mid-term. Kenya 2010, 2012.

Reason	Nairobi		Mombasa		Kisumu	
	Baseline	Mid-term	Baseline	Mid-term	Baseline	Mid-term
<b>Fertility related reasons</b>						
Infrequent sex / no sex / not married yet / no partner	46.1	51.3	44.6	41.7	40.1	38.8
Away from spouse	6.7	2.5	3.7	7.4	7.3	1.4
Already pregnant	9.7	10.3	9.4	4.6	12.8	2.0
Breastfeeding	5.6	5.1	4.0	4.4	9.0	4.7
Wants more children	10.2	13.0	11.8	11.4	13.2	7.7
Menopausal / hysterectomy	1.3	1.4	2.4	3.7	1.7	1.9
Can't have more children	1.8	1.8	2.6	2.1	3.6	4.5
<b>Opposition to use</b>						
Respondent opposes	6.8	1.4	9.5	3.9	6.4	7.6
Partner opposes	2.2	0.2	2.7	1.2	5.1	1.7
Others oppose	0.5	0.0	1.1	0.0	1.3	0.8
Religious prohibition	2.6	4.4	4.6	5.2	2.8	1.7
<b>Lack of knowledge</b>						
Don't know which method to use	2.6	0.7	2.2	1.2	4.2	0.6
Don't know how to use method	2.3	0.0	2.6	1.4	6.0	0.4
Knows no source	0.2	0.3	0.8	0.0	0.7	0.1
<b>Method-related reasons</b>						
Health concerns	9.8	6.5	7.0	10.7	10.4	14.6
Fear of side effects	9.2	7.2	10.6	4.7	16.3	14.6
Lack of access / too far	0.0	0.1	0.0	0.6	0.1	0.0
Costs too much	0.0	0.3	0.2	0.5	0.4	0.7
Inconvenient to use	0.3	0.5	0.1	0.8	0.0	0.3
Don't like existing methods	2.3	0.1	0.4	1.5	1.4	0.8
Bad experience with existing methods	2.1	1.2	2.1	0.9	1.2	1.4
<b>Fatalistic</b>						
Up to God	0.4	0.2	1.7	0.6	1.8	1.1
<b>Other*</b>	1.0	1.4	0.2	0.7	0.2	1.2
<b>Don't know</b>	1.2	0.0	0.2	0.0	0.5	0.4

Note: Percentages may not sum to 100% because multiple responses could be given

Note: The small number of respondents with missing responses are not included in the indicator calculation

\*Other includes not interested, decided not to

**Table 4.11. Reasons for non-use of contraception among men**

Percent of men by reasons for non-use of contraception at baseline and mid-term. Kenya 2010, 2012.

Reason	Baseline	Mid-term
<b>Fertility related reasons</b>		
Infrequent sex / no sex / not married yet / no partner	38.6	48.0
Away from spouse	6.0	5.1
Already pregnant	4.2	5.4
Breastfeeding	4.2	1.6
Wants more children	13.0	11.5
Menopausal / hysterectomy	8.6	7.8
Can't have more children	5.1	0.0
<b>Opposition to use</b>		
Respondent opposes	3.6	11.4
Partner opposes	1.1	1.2
Others oppose	0.0	0.0
Religious prohibition	4.0	6.4
<b>Lack of knowledge</b>		
Don't know which method to use	0.7	1.1
Don't know how to use method	0.4	0.0
Knows no source	0.0	0.1
<b>Method-related reasons</b>		
Health concerns	3.3	1.3
Fear of side effects	6.2	2.6
Lack of access / too far	0.0	0.0
Costs too much	0.0	0.0
Inconvenient to use	0.0	0.9
Don't like existing methods	3.4	0.9
Bad experience with existing methods	1.1	1.6
<b>Fatalistic</b>		
Up to God	3.6	1.2
<b>Don't know</b>	1.2	0.0

Note: Percentages may not sum to 100% because multiple responses could be given.

Note: The small number of respondents with missing responses are not included in the indicator calculation

## Attitudes towards FP methods

### *Attitudes towards long-acting contraceptive methods*

All women were asked about the most common side effects of IUDs and implants. Table 4.12 presents results on the perceived side effects of these two methods. Across all cities, women associated the implant with a number of side effects including bleeding/menstrual problems, weight gain or loss, weakness, and headaches. In contrast, the IUD was primarily associated with bleeding or menstrual problems, with far fewer women mentioning other possible side effects. However, some women (4 to 16 percent) reported that IUD strings may interfere with sexual

pleasure and, between 12 and 18 percent of women believe that an IUD can move around within the body. Between 3 and 8 percent believed the IUD is not a very effective method. Few women thought that either the IUD or the implant could lead to more serious problems such as infertility, cancer, fetal harm or birth defects. Overall, 30 to 42 percent of women did not know of any disadvantages of the implant; 40 to 52 percent of women did not know of any disadvantages of the IUD.

### *Perceived quality of FP service delivery*

All women, regardless of whether or not they currently use FP, were asked whether they agreed with a series of questions about the ways FP providers interact with clients. Table 4.13 shows that at baseline, few women in Kisumu or Mombasa (6 to 10 percent) agreed with each of the three statements, with no discernible pattern among the age groups. Women in Nairobi at baseline appeared to be more dissatisfied with provider treatment; one in four women agreed with the statement “Women don't like the way they are treated in FP clinics around here” and about 20 percent agreed that “FP providers around here treat clients very badly”. These perceptions improved in Nairobi by mid-term, particularly with respect to women feeling they are treated badly at FP clinics, which dropped from 25 percent to 18 percent. Women in Nairobi aged 20-35 were more likely to express dissatisfaction with provider treatment of clients at baseline, although this pattern was not apparent by mid-term. In Mombasa and Kisumu overall, small increases occurred in the percent of women that agreed with all three statements. At mid-term respondents were also asked whether they agreed with the statement: “I hesitate to seek FP service because of the way the providers treat clients;” between 6 (Kisumu) and 12 (Nairobi) percent of women agreed. In Kisumu, older women (ages 40 or above) were less likely to express dissatisfaction with provider treatment at mid-term on all four questions. Results of the facility survey and client exit interviews provide additional insights into service quality; these results are presented in Chapter 8.

### **FP method switching between baseline and mid-term**

#### *Changes in FP method use*

Tables 4.14 and 4.15 present data on method switching between baseline and mid-term using only women in the matched baseline and mid-term matched sample. A little more than half of all women surveyed at baseline and at mid-term were not using any method of contraception at the time of the baseline survey. By mid-term, nearly one in five women (17 percent) from the baseline survey had switched from non-use to a modern method. A greater percentage of women ages 15-24, never married women and women without children at the time of the baseline survey are in the group that switched from ‘no method’ to ‘modern method’ use. A small number of women (4 percent) switched from non-use to traditional method use, while one-third remained non-users at mid-term. A greater percentage of women who were non-users at both survey periods were 15-19 years of age at the time of the baseline survey, had no education, were childless at baseline or were unmarried at baseline. Only a small number of women were using traditional methods at baseline and approximately half of these women switched to modern methods by mid-term. About 40 percent of women surveyed at baseline were using a modern FP method at baseline but 30 percent of these had discontinued by mid-term; the women who had discontinued use of a modern FP method between the baseline and mid-term surveys were primarily those in their twenties with some education and only one child. Those who maintained modern method use at both time periods (27 percent) were more likely to be in their thirties, married, with at least some education and with 2 to 3 children at the time of the baseline survey. In Mombasa, a greater percentage of women remained non-users between baseline and mid-term, and a larger percentage of modern FP users at baseline discontinued by mid-term.

**Table 4.12. Perceptions about implants and IUDs**

Percent of women that reported knowing about the following side effects regarding implants and IUDs by city at mid-term. Kenya 2012.

	Nairobi	Mombasa	Kisumu
<b>Implant</b>			
<b>Reported, known side effects or complications*</b>			
Bleeding or menstrual problems	30.2	26.6	36.8
Weight gain	22.7	18.3	17.6
Weight loss	17.7	15.4	18.6
Headaches	14.0	8.7	14.1
Nausea / vomiting	6.5	6.5	7.2
Lack of sexual urge	4.6	3.2	4.4
Can come out of my arm	2.6	2.5	1.3
<b>Other side effects reported by respondents</b>			
Backaches	9.8	6.9	12.2
Sleeplessness	0.8	2.1	1.8
Weakness	12.1	12.6	21.0
Other health problems	16.7	14.5	21.3
Infertility	6.0	4.5	1.1
Cancer	2.0	3.1	1.5
Deformed children	2.5	0.6	1.3
Can move around in my body	4.1	3.7	3.1
Can harm fetus if become pregnant	1.2	0.9	1.3
Other	6.1	9.3	13.7
<b>Don't know method</b>	4.0	4.9	2.8
<b>Knows no side effects / disadvantages</b>	30.4	41.9	30.7
<b>IUD</b>			
<b>Reported, known side effects or complications*</b>			
Bleeding or menstrual problems	17.9	11.8	11.9
Strings interfere partner sexual pleasure	16.0	9.6	4.2
Infertility	4.0	2.7	1.3
<b>Other side effects reported by respondents</b>			
Weight gain	5.5	5.1	3.8
Weight loss	6.1	3.9	3.4
Headaches	2.7	2.4	2.1
Backaches	5.2	6.2	5.4
Nausea / vomiting	1.2	2.7	1.5
Sleeplessness	0.2	2.0	0.4
Weakness	3.8	2.4	3.6
Lack of sexual urge	2.7	2.8	1.9
Other health problems	9.9	10.2	12.2
Cancer	5.3	7.6	3.7
Birth defects	4.6	5.9	3.6
Can move around within body	18.2	12.1	13.6
Ineffective / can become pregnant while using	4.6	7.6	3.1
Other	10.0	15.2	11.1
<b>Don't know method</b>	4.3	8.5	6.5
<b>Knows no side effects / disadvantages</b>	39.5	45.6	52.4

\* "Known" side effects include those published in Family Planning: A Global Handbook for Providers. 2007.

Note: Multiple responses could be given so percentages do not sum to 100%

Note: The small number of respondents with missing responses are not included in the indicator calculation

**Table 4.13. Perceived quality of care for FP services**

Percent of women with that agree or strongly agree with statements on perceived quality of care for FP services by wealth quintile and city, at baseline and mid-term. Kenya 2010, 2012.

		Baseline			Mid-term			
		"Family planning providers around here treat clients very badly"	"Women don't like the way they are treated in family planning clinics around here"	"Family planning sellers/providers make women like you feel bad when obtaining contraceptives"	"Family planning providers around here treat clients very badly"	"Women don't like the way they are treated in family planning clinics around here"	"Family planning sellers/providers make women like you feel bad when obtaining contraceptives"	"I hesitate to seek family planning service because of the way the providers treat clients"
<b>Nairobi</b>	Age group							
	15-19	15.0	16.3	11.7	14.9	12.3	9.8	10.5
	20-24	21.9	29.6	16.0	18.4	19.5	15.4	18
	25-29	20.4	23.4	14.6	17.1	15.5	15.2	9.4
	30-34	23.4	26.7	18.3	17.3	19.5	14.3	8.9
	35-39	17.5	24.9	15.5	20.5	20.1	14.3	9.9
	40-44	18.1	16.9	9.2	11.7	14.5	10.9	10.8
	45-49	8.3	12.2	12.3	13	17.8	18.2	5.4
	Overall	19.9	24.5	15.0	17.2	17.5	14.3	12.1
<b>Mombasa</b>	Age group							
	15-19	11.1	15.1	13.6	9.5	15.5	17.1	21.4
	20-24	5.9	8.4	6.8	14.8	10.9	12.1	8.4
	25-29	9.9	10.8	10.2	7.8	11.1	7.8	5.9
	30-34	6.7	6.8	6.7	8.2	7.8	6.7	6.7
	35-39	7.1	9.8	7.9	16.4	15.6	13.1	7.2
	40-44	6.2	9.2	7.5	7.5	14	12.4	9.3
	45-49	13.6	13.9	9.9	4.2	3.9	6.9	11.3
	Overall	8.2	10.0	8.7	10.4	11.6	11	9.8
<b>Kisumu</b>	Age group							
	15-19	5.6	8.8	6.0	9.9	11.7	9.4	8
	20-24	6.2	8.3	3.9	8.6	11.3	6.3	6.1
	25-29	8.9	9.2	6.9	8.8	11.8	8	7.2
	30-34	8.3	9.8	6.6	6.7	13.1	7	4.7
	35-39	6.6	9.3	8.5	7.9	8.6	9.3	6.9
	40-44	3.4	10.4	6.3	6.4	7.5	3.6	2.6
	45-49	1.6	3.7	3.7	5.1	9.3	11.1	0.5
	Overall	6.7	8.8	5.8	8.3	11.2	7.6	6.2

Note: The small number of respondents with missing responses are not included in the indicator calculation

**Table 4.14. Contraceptive method switching between baseline and mid-term**

Percent distribution of women's contraceptive method switching between baseline and mid-term surveys by baseline background characteristics at baseline and mid-term. Kenya 2010, 2012.

	Baseline <sup>1</sup> 2010	Non-user ↓ Modern method <sup>3</sup>	Non-user ↓ Traditional method <sup>4</sup>	Non-user ↓ Non-user	Traditional method ↓ Modern method	Traditional method ↓ Traditional method	Traditional method ↓ Non-user	Modern method ↓ Modern method	Modern method ↓ Traditional method	Modern method ↓ Non-user	Total	Number of women
<b>Baseline age</b>												
15-19		21.3	3.5	62.2	0.3	0.0	0.3	3.3	0.5	8.6	100.0	370
20-24		20.8	3.9	31.0	1.5	0.5	0.7	26.5	1.9	13.4	100.0	941
25-29		18.8	4.1	23.7	1.6	1.1	0.8	30.1	2.8	17.0	100.0	774
30-34		16.2	3.7	20.0	3.1	2.5	1.6	37.2	5.4	10.3	100.0	472
35-39		7.7	3.2	32.2	2.1	2.1	1.7	38.0	2.6	10.4	100.0	323
40-44		10.0	8.4	39.6	0.5	3.4	0.3	23.9	1.6	12.4	100.0	210
45-49		9.1	3.9	56.2	3.6	0.0	1.0	15.0	1.4	9.8	100.0	117
<b>Baseline education<sup>2</sup></b>												
No education		17.2	2.3	62.2	0.1	0.0	2.0	8.2	1.2	6.8	100.0	106
Primary incomplete		19.1	3.7	31.4	2.4	0.6	0.6	30.0	0.7	11.4	100.0	436
Primary		19.8	5.2	31.3	1.1	0.9	0.7	27.5	3.1	10.5	100.0	862
Secondary and above		15.5	3.8	32.2	1.9	1.6	1.0	26.9	2.7	14.5	100.0	1,802
<b>Marital Status<sup>2</sup></b>												
Never married		19.6	5.6	50.6	1.4	0.7	0.6	8.9	1.4	11.1	100.0	1,035
Married / living together		16.4	3.6	19.7	2.0	1.8	1.1	38.2	3.2	13.9	100.0	1,841
Separated / divorced		13.5	2.3	48.7	0.8	0.1	1.3	16.5	2.2	14.7	100.0	229
Widowed		16.7	1.3	56.7	0.8	0.0	0.1	19.6	0.6	4.2	100.0	94
<b>Baseline wealth Index</b>												
Poorest		22.3	6.1	33.5	2.2	1.1	1.3	22.9	3.3	7.3	100.0	543
Poor		16.9	4.4	31.5	0.9	0.6	1.6	25.6	2.0	16.5	100.0	616
Middle		14.1	3.1	26.3	2.0	0.6	0.5	37.2	1.8	14.3	100.0	625
Rich		22.0	2.9	30.3	1.3	1.3	0.7	28.5	2.1	10.9	100.0	646
Richest		12.4	4.3	40.7	2.0	2.2	0.6	20.7	3.1	13.9	100.0	777
<b>Baseline live births</b>												
No children		20.4	6.2	57.0	1.6	0.5	0.3	5.4	0.4	8.1	100.0	901
1 child		19.5	3.2	22.3	1.3	2.0	1.4	27.2	3.0	20.1	100.0	877
2 children		15.5	2.6	21.5	1.6	0.8	0.7	41.2	2.9	13.1	100.0	653
3 children		13.3	3.0	19.2	2.2	1.1	1.6	44.0	5.5	10.2	100.0	394
4 children		11.2	3.6	31.1	4.0	3.6	1.1	32.3	2.0	11.1	100.0	180
5 children		14.2	7.4	31.6	0.2	0.8	0.4	39.8	0.5	5.0	100.0	115
6+ children		8.8	3.8	38.9	1.5	2.0	0.1	30.5	5.2	9.1	100.0	87
<b>Baseline city</b>												
Nairobi		17.9	3.5	29.7	1.8	1.3	0.7	28.6	2.8	13.7	100.0	1,333
Mombasa		14.2	6.3	45.3	1.3	1.1	1.5	18.7	1.8	9.7	100.0	933
Kisumu		20.3	3.1	26.1	1.5	0.8	1.7	33.7	1.2	11.7	100.0	941
<b>Total</b>		<b>17.2</b>	<b>4.1</b>	<b>32.8</b>	<b>1.7</b>	<b>1.2</b>	<b>0.9</b>	<b>26.8</b>	<b>2.5</b>	<b>12.7</b>	<b>100.0</b>	<b>--</b>
Number of women		<b>552</b>	<b>131</b>	<b>1,052</b>	<b>54</b>	<b>40</b>	<b>29</b>	<b>860</b>	<b>79</b>	<b>409</b>	<b>--</b>	<b>3,207</b>

1 Baseline estimates include all women successfully interviewed at baseline and mid-term

2 A small number of women had missing information on education and marital status at baseline and were dropped from this indicator

3 Modern methods include male/female sterilization, daily pill, IUD, injectables, male condom, female condom, LAM/breastfeeding, implants and E-pill

4 Traditional methods include periodic abstinence, withdrawal, and standard days/safe days/cycle beads

Regarding specific methods, those who switched from non-use at baseline to modern method use at mid-term more often chose injectables (12 percent) over any other method, followed by implants (6 percent) and pills (4 percent) (see Table 4.15). Users of condoms, the daily pill, E-pill and other modern methods at baseline were not likely to report they were still using that method at mid-term. About 54 percent of IUD users at baseline were not using IUD at mid-term. Switching from a modern method to non-use was highest for implant users (35 percent), followed by users of injectables (29 percent) and daily pills (28 percent). Also of note, 24 percent of daily pill users switched to the injectable. Overall, non-users at baseline of all types of contraception dropped from 54 percent to 47 percent at mid-term.

**Table 4.15. Contraceptive method use at baseline and mid-term**

Percent of women that switched contraceptive methods between baseline and mid-term, by method. Kenya 2010, 2012.

Baseline <sup>1</sup> method use	Mid-term method use										Total	Number of women
	Nonuse	Sterilization	Implant	IUD	Injectables	Daily pill	E-pill	Male condom	Other modern method <sup>2</sup>	Traditional method <sup>3</sup>		
Nonuse	60.6	1.1	5.8	0.7	12.0	4.2	0.3	7.0	0.9	7.6	100.0	1,735
Sterilization	14.7	84.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100.0	47
Implant	34.6	2.5	43.0	7.9	4.6	0.0	0.0	0.9	0.0	6.6	100.0	77
IUD	22.1	0.3	8.0	46.2	8.4	5.0	0.0	0.0	0.0	9.9	100.0	71
Injectables	29.2	0.6	7.9	2.1	43.4	7.0	0.8	3.3	0.3	5.5	100.0	562
Daily pill	27.8	0.4	6.1	2.3	23.6	30.1	0.6	3.4	0.6	5.1	100.0	342
E-pill	78.9	0.7	0.8	0.0	3.7	0.0	0.0	1.7	0.0	14.2	100.0	28
Male condom	36.3	3.7	6.3	1.0	11.2	11.6	1.2	21.8	1.0	6.0	100.0	205
Other modern method <sup>2</sup>	25.8	9.0	0.0	2.5	7.3	30.4	0.0	0.9	8.9	15.3	100.0	16
Traditional method <sup>3</sup>	24.3	2.6	6.0	4.3	7.9	6.1	0.2	14.2	2.3	32.3	100.0	124
Total	46.5	2.4	7.0	2.4	18.0	7.9	0.4	6.7	0.8	7.8	100.0	3,207

1 Baseline estimates include all women successfully interviewed at baseline and mid-term

2 Other modern methods include female condom and LAM/breastfeeding

3 Traditional methods include periodic abstinence, withdrawal, and standard days/safe days/cycle beads

## Chapter 5. Maternal and child health

This chapter presents the mid-term findings on key maternal and child health indicators, with baseline comparisons where available. At baseline and again at mid-term, women were asked a series of detailed questions about the most recent live birth within two years prior to the survey.

### Place of delivery

At baseline, women that gave birth since 2008 were asked where the last birth since 2008 took place. At mid-term, women that gave birth since 2010 were asked where the last birth since 2010 took place. Results on place of delivery at baseline and mid-term are presented in Table 5.1. The majority of women in Nairobi, Mombasa and Kisumu delivered their most recent birth in a health facility, both at baseline and at mid-term. The share of deliveries in public facilities declined in Nairobi and Mombasa, yet increased in Kisumu. The percentage of women that delivered their last child in a private facility increased across all 3 cities. In Nairobi, 42 percent of deliveries at baseline were in a private facility, while at mid-term the percentage rose to almost 50 percent. In Mombasa, deliveries in a private facility increased by 7 percentage points, to 39 percent at mid-term. The percentage of deliveries in a private facility increased the most in Kisumu, with an increase of 8 percentage points at mid-term. The percentage of women that delivered at home declined noticeably in Kisumu, decreasing from 17 percent at baseline to 7 percent at mid-term. The percentage of home deliveries remained about the same in Mombasa with approximately 20 percent of all births taking place at home in both time periods, and increased slightly in Nairobi from 10 percent at baseline to 13 percent at mid-term.

**Table 5.1. Place of delivery**

Percent distribution of last births since 2008 among women at baseline and 2010 among women at mid-term, by place of delivery by city. Kenya 2010, 2012.

Facility type	Nairobi		Mombasa		Kisumu	
	Baseline	Mid-term	Baseline	Mid-term	Baseline	Mid-term
Public facility	46.3	36.2	41.9	35.4	48.6	53.3
Private facility	41.8	49.5	32.0	39.2	25.4	33.8
Home	10.0	13.3	22.0	21.1	16.9	6.9
Other*	1.9	1.1	4.2	4.3	9.1	6.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women with a birth	777	451	422	309	608	320

\*Other facilities include reports of individuals (TBA, community midwife, etc..)

Note: Some women had missing data for date of last birth and were not included in the table

Note: The small number of respondents with missing responses are not included in the indicator calculation

### Assistance at delivery

Most of the recent births at baseline and mid-term in all three study cities were attended by a doctor or skilled health care provider, as presented in Table 5.2. In Nairobi, a doctor or clinical officer attended about 60 percent of births at baseline and mid-term. Skilled attendance by a nurse or trained midwife also remained about the same in Nairobi, at about 31 percent. In Mombasa, attendance by a doctor or clinical officer increased from 48 percent to 55 percent, while skilled attendance by a nurse or trained midwife decreased about 5 percentage points, to 24 percent overall. In contrast to the other two cities, Mombasa experienced an increase in use of traditional birth

attendants (from 8 to 14 percent) and a drop in assistance from friend or relatives from 12 to 5 percent. In Kisumu, as in the other cities, attendance by a doctor or clinical officer rose about 3 percentage points, to 47 percent of recent births at mid-term. Unlike the other study cities, attendance by a nurse or trained midwife increased in Kisumu, from 33 percent at baseline to 43 percent of recent births at mid-term.

**Table 5.2. Assistance at delivery**

Percent distribution of last births since 2008 among women at baseline and 2010 among women at mid-term, by type of person providing assistance during delivery, by city. Kenya 2010, 2012.

Facility type	Nairobi		Mombasa		Kisumu	
	Baseline	Mid-term	Baseline	Mid-term	Baseline	Mid-term
Doctor / clinical officer	59.9	59.0	48.4	54.6	43.8	46.8
Nurse / midwife	31.1	31.3	29.5	24.4	32.7	43.4
TBA	2.0	1.4	7.9	13.6	14.7	5.8
Community health worker	1.1	0.4	0.6	0.0	3.1	0.7
Friend or relative	4.7	6.9	12.2	4.7	2.9	2.2
No one	1.1	1.2	1.3	2.6	2.8	1.1
Number of births	775	463	421	307	608	332

Note: If more than one person attended the delivery, only the most qualified health provider mentioned is counted in this tabulation.

Note: The small number of respondents with missing responses are not included in the indicator calculation

### Exposure to FP information or counseling at time of delivery

Women that gave birth in a health facility since 2008 at baseline and since 2010 at mid-term were asked about their exposure to FP information and counseling at the time of their last delivery in a health facility. At baseline, few women in any of the three study cities received information or counseling on FP at the facility before the delivery of the child, whether at public or private facilities. In Nairobi, at the time of the last delivery, only 15 percent of women at public facilities received information before the delivery, and only 16 percent of women received information at private facilities. At mid-term, this percentage rose substantially to about 37 percent of last births in public facilities and 21 percent at private facilities. In Mombasa, baseline exposure to FP information prior to delivery at the facility was also low, at 15 percent in public facilities and 10 percent in private facilities. By mid-term, the percent of women at last birth that received FP information at the facility prior to giving birth rose to 46 percent in public facilities and 28 percent in private facilities. Kisumu experienced the greatest increase in the public sector, where exposure to FP information in the facility prior to giving birth increased to 51 percent at mid-term. In private facilities, the percent increased from 10 percent to 29 percent at mid-term.

**Table 5.3. Exposure to FP information/counseling at time of delivery**

Percent distribution of women by exposure to FP information/counseling at time of delivery of last live birth at a health facility since 2008 among women at baseline, and since 2010 among women at mid-term, by type of facility and city. Kenya 2010, 2012

	Nairobi				Mombasa				Kisumu			
	Baseline		Mid-term		Baseline		Mid-term		Baseline		Mid-term	
	Public	Private										
Received information or counseling on FP before delivery, when at the facility for delivery	n = 359	n = 339	n = 167	n = 234	n = 177	n = 152	n = 109	n = 134	n = 296	n = 210	n = 177	n = 132
Yes	14.6	16.1	37.1	21.3	15.0	10.1	45.6	27.7	11.5	9.9	50.6	28.6
No	85.4	83.9	62.9	78.7	85.0	89.9	54.4	72.3	88.5	90.1	49.4	71.4
Received information or counseling on FP after delivery, when at the facility for delivery	n = 359	n = 339	n = 167	n = 234	n = 177	n = 152	n = 109	n = 134	n = 296	n = 210	n = 177	n = 132
Yes	54.3	51.0	60.6	51.1	53.6	35.9	71.7	63.5	57.3	36.3	73.7	53.5
No	45.7	49.0	39.4	48.9	46.4	64.1	28.3	36.5	42.7	63.7	26.3	46.5
Received information or counseling on FP before AND after delivery, when at the facility for delivery	n = 359	n = 339	n = 167	n = 234	n = 177	n = 152	n = 109	n = 134	n = 296	n = 210	n = 177	n = 132
Yes	6.1	8.0	28.8	15.5	10.2	6.3	43.8	26.1	4.2	3.8	44.5	27.8
No	93.9	92.0	71.2	84.5	89.8	93.7	56.2	73.9	95.8	96.2	55.5	72.2
Received any information or counseling on FP before OR after delivery, when at facility for delivery	n = 359	n = 339	n = 167	n = 234	n = 177	n = 152	n = 109	n = 134	n = 296	n = 210	n = 177	n = 132
Received counseling/information	62.9	59.1	69.0	56.8	58.5	39.7	73.5	65.2	64.7	42.4	79.8	54.4
Did not receive any counseling/information	37.1	40.9	31.0	43.2	41.5	60.3	26.5	34.8	35.3	57.6	20.2	45.6

Note: The small number of respondents with missing responses are not included in the indicator calculation

Women that gave birth recently were also asked whether they received information or counseling on FP after the delivery, while still at the facility. By mid-term, a majority of women in all three study cities received FP information or counseling after the delivery yet before leaving the facility. Kisumu and Mombasa experienced relatively large increases by mid-term. In Mombasa, the percentage of women that received FP counseling or information after delivery while at a public health facility increased about 18 percentage points to 72 percent at mid-term. The increase was even larger at mid-term in private facilities; almost 64 percent of women received such information after the last birth in a facility.

In Kisumu, the percent of women that received FP counseling or information in public facilities before and after delivery, while still at the facility, rose 41 percentage points to almost 45 percent at mid-term. Among births in private facilities, the percentage of women that received FP information or counseling before and after delivery, while still at the facility, increased from 4 percent at baseline to almost 28 percent at mid-term.

The percentage of women that received no counseling or information on FP before or after their last recent delivery in a public health facility decreased across all three study cities. The declines were greater in Mombasa and Kisumu than in Nairobi; despite these decreases, at mid-term 20 to 31 percent of women in public facilities

received no information on FP at any point before or after their delivery. In private facilities, the declines were greatest in Mombasa and Kisumu, while Nairobi stayed about the same between the two time periods.

### Exposure to FP information/counseling during child health visits

Women with at least one living child were asked whether they had gone to a health facility for child health services in the past year. Women who had taken their child for health services in the past year were then asked whether they had received any information on FP during the visit. These results are presented in Table 5.4. While a majority of women at mid-term did not receive information on FP during the last child health visit, this percentage declined since baseline. More women received information on FP at mid-term as compared to baseline in all three study cities, though these women did not receive a referral, prescription or a method at the child health visit. In Nairobi, 12 percent of women that had gone to a facility for a child health visit in the last year received information but nothing else; by mid-term, 34 percent of women had received information, though not a method, referral or prescription. In Mombasa, 24 percent of women at mid-term received FP information only, compared to 11 percent at baseline. About 29 percent of women in Kisumu that had gone to a facility for a child health visit in the past year at mid-term received information only, compared to about 14 percent at baseline.

**Table 5.4. Exposure to family planning information/counseling during child health visits**

Percent distribution of women with at least one child that were exposed to FP information/counseling during the last child health visit, by city at baseline and mid-term. Kenya 2012.

	Nairobi		Mombasa		Kisumu	
	Baseline n = 601	Mid-term n = 621	Baseline n = 326	Mid-term n = 417	Baseline n = 510	Mid-term n = 437
Received no info on FP	73.4	54.4	77.9	68.4	79.0	56.5
Received a method	9.0	7.9	3.1	3.8	4.9	7.7
Received a prescription	4.3	1.9	5.4	2.8	2.2	3.8
Received a referral	1.2	2.2	2.9	0.7	0.1	2.7
Received info, but no referral, prescription or method	12.1	33.7	10.8	24.4	13.7	29.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: The small number of respondents with missing responses are not included in the indicator calculation

### Timing of postpartum contraceptive use

At mid-term, women who had given birth since January 2010 were asked whether they had adopted a contraceptive method within 12 months of delivery of the last live birth. If so, they were asked the timing of the adoption of the FP method. At mid-term, among women that gave birth recently, 23 percent of women in Nairobi, 37 percent in Mombasa and 22 percent in Kisumu did not adopt a FP method within 12 months of delivery of the last live birth. About 6 percent of women that gave birth since 2010 in Nairobi adopted a modern method immediately after delivery; 8 percent adopted a method immediately in Mombasa. In Kisumu, 22 percent of women that delivered a live-born child since 2010 adopted a method immediately after delivery. Among those women that did adopt any FP method within 12 months of delivery, most adopted the method within two months of the delivery. About 41 percent of women in Nairobi adopted any method within two months of delivery. In Mombasa, 27 percent of women that had a child since 2010 adopted any method within two months of delivery, and in Kisumu 33 percent adopted any method. This question was not asked in the baseline survey, so no comparisons are available.

**Table 5.5. Timing of postpartum contraceptive use**

Percent distribution of women that had a live birth since January 2010 and timing of the adoption of any contraceptive method postpartum, by city at mid-term. Kenya 2012.

	<b>Nairobi</b>	<b>Mombasa</b>	<b>Kisumu</b>
	n = 463	n = 306	n = 327
Did not adopt FP within 12 months postpartum	22.8	37.0	22.1
Adopted immediately after delivery	6.1	7.6	21.8
Adopted 0 - 2 months	40.8	26.8	33.1
Adopted 3 - 5 months	14.3	17.8	14.0
Adopted 6 - 12 months	16.1	10.8	9.0
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Note: The small number of respondents with missing responses are not included in the indicator calculation

### Postpartum contraceptive use by method

Women who had given birth since January 2010 and had adopted any contraceptive method within 12 months of delivery of the last live birth were then asked to specify the contraceptive method they had adopted. Table 5.6 presents these results. Among women that adopted any contraceptive method within 12 months of the last birth since 2010, most of these women began using injectables. In Nairobi, 33 percent of women who had a birth since 2010 began using injectables; in Mombasa 29 percent of these women began using injectables, and in Kisumu 34 percent of these women began using injectables. The daily pill was also popular in Nairobi, where 18 percent of women chose to use the pill within 12 months after the last delivery. The implant was another popular method, with use ranging from 10 percent in Nairobi and Mombasa to 18 percent in Kisumu. A substantial proportion of women that delivered a child since January 2010 did not adopt any method within 12 months of the last delivery; 23 percent in Nairobi, 37 percent in Mombasa and 22 percent in Kisumu.

**Table 5.6. Postpartum contraceptive use**

Percent distribution of women that had a live birth since January 2010 and postpartum contraceptive use and method, by city at mid-term. Kenya 2012.

	<b>Nairobi</b>	<b>Mombasa</b>	<b>Kisumu</b>
	n = 463	n = 307	n = 332
<b>Modern Methods</b>			
Sterilization	1.5	2.4	1.3
Implant	9.5	10.1	17.5
IUD	2.4	1.4	1.7
Injectables	32.9	28.5	33.7
Daily pill	18.2	6.4	4.8
Male condom	3.1	2.1	7.4
LAM / breastfeeding	3.6	4.4	8.4
Other modern method <sup>1</sup>	0.0	0.7	0.4
<b>Traditional method<sup>2</sup></b>	<b>6.0</b>	<b>7.2</b>	<b>3.2</b>
<b>Not using a method</b>	<b>22.7</b>	<b>36.8</b>	<b>21.7</b>
<b>Any method</b>	<b>77.3</b>	<b>63.2</b>	<b>78.3</b>

1 Other modern methods include female condom and E-pill

2 Traditional methods include periodic abstinence, withdrawal, and standard days/safe days/cycle beads

### Miscarriages, abortions and stillbirths

All women at mid-term were asked whether they had ever experienced a miscarriage, abortion or stillbirth in their lifetime. These questions were not asked at the time of the baseline survey. In Nairobi and Kisumu, 8 and 9 percent of women had ever experienced at least one such event, respectively, while in Mombasa, almost 17 percent of women had ever experienced at least one of these events. Among women who ever experienced a miscarriage, abortion or stillbirth, the most commonly reported event in the last two years was a miscarriage. Almost 32 percent of women who had ever experienced a miscarriage, stillbirth or abortion in Mombasa had a miscarriage within the last two years. Among women in Nairobi, about 22 percent of those that ever had a miscarriage, stillbirth or abortion had a miscarriage within the last two years, and about 20 percent of women in Kisumu had a recent miscarriage.

**Table 5.7. Miscarriages, abortions and stillbirths**

Percent distribution of women that have experienced a miscarriage, abortion or stillbirth, at mid-term. Kenya 2012.

	Nairobi	Mombasa	Kisumu
Ever miscarried, had an abortion or stillbirth	n = 1,329	n = 933	n = 941
Yes	8.2	16.8	8.8
No	91.8	83.2	91.2
Had a stillbirth within the last two years	n = 109	n = 156	n = 80
Yes	2.8	3.8	0.4
No	97.2	96.2	99.6
Had a miscarriage within the last two years	n = 107	n = 157	n = 80
Yes	21.6	32.4	19.9
No	78.4	67.6	80.1
Had an abortion within the last two years	n = 103	n = 156	n = 77
Yes	5.4	2.0	2.0
No	94.6	98.0	98.0

Note: The small number of respondents with missing responses are not included in the indicator calculation

Abortion in Kenya has always been legal if conducted to protect the life of the mother; in the 2010 Kenyan Constitution, this was expanded to include emergency treatment, cases where the health of the mother is in danger or otherwise needed as determined by the opinion of a trained health professional (Gutmacher 2012). At mid-term, 5 percent of women in Nairobi that reported ever experiencing a miscarriage, stillbirth or abortion reported that they had had an abortion within the last two years. In Mombasa and Kisumu, 2 percent of women reported a recent abortion, among those that had ever experienced any miscarriage, stillbirth or abortion.

Of all women that had ever experienced any of the three events, 3 percent of women in Nairobi, 4 percent in Mombasa and less than 1 percent of women in Kisumu reported having delivered a stillbirth in the last two years.

## Chapter 6. Perceptions of FP support, discussion and decision making on FP

### Perceptions of community support for FP

At baseline and mid-term, women were asked if they had heard local government officials or religious leaders speak in favor of family planning/contraception in the last year. In addition, at baseline, women were asked if they had heard local/government officials or religious leaders speak against family planning/contraception. Table 6.1 shows that in Nairobi and Mombasa, roughly half of women reported hearing a government official speak in favor of FP whereas in Kisumu, it was about 70 percent. These percentages were largely unchanged between baseline and mid-term. A smaller percentage of women reported having heard positive remarks on FP from religious leaders. At baseline and mid-term, only 21-23 percent of the women in Mombasa reported hearing religious leaders speak positively about FP. The percentage of women that reported hearing positive remarks from a religious leader increased from 26 percent to 35 percent in Nairobi between baseline and mid-term.

**Table 6.1. Women's perceptions of FP community support**

Percent distribution of women by their perceptions of community-level support of FP, by city at baseline and mid-term. Kenya 2010, 2012.

	Nairobi		Mombasa		Kisumu	
	Baseline	Mid-term	Baseline	Mid-term	Baseline	Mid-term
Have heard a Government / Municipality official speak AGAINST FP/child birth spacing in the last year						
Yes	13.0	N/A	14.9	N/A	22.5	N/A
No	84.6	N/A	79.6	N/A	75.7	N/A
Don't remember	2.5	N/A	5.4	N/A	1.7	N/A
Have heard a government / municipality official speak FOR FP/child birth spacing in the last year						
Yes	53.2	56.5	48.6	47.1	72.1	71.2
No	44.4	43.5	45.4	52.9	25.5	28.8
Don't remember	2.4	N/A	6.0	N/A	2.4	N/A
Have heard a religious leader speak AGAINST FP/child birth spacing in the last year						
Yes	35.7	N/A	36.0	N/A	43.7	N/A
No	62.6	N/A	60.3	N/A	54.0	N/A
Don't remember	1.8	N/A	3.6	N/A	2.3	N/A
Have heard a religious leader speak FOR FP/child birth spacing in the last year						
Yes	25.8	35.1	21.0	23.1	35.5	28.5
No	71.6	64.9	74.7	76.9	61.5	71.5
Don't remember	2.6	N/A	4.3	N/A	3.0	N/A
Number of women	2,706	1,333	1,465	933	1,603	941

## Approval of FP

Men's and women's approval of FP is presented in Table 6.2. Approval of FP in urban Kenya is universally high, with explicit approval over 90 percent among male and female respondents in Nairobi and Kisumu. In Mombasa, 88 percent of women and 90 percent of men approved of FP.

**Table 6.2. Women's and men's attitudes toward family planning**

Percent distribution of women and men by approval of FP at mid-term, by city at mid-term. Kenya 2012.

	Women			Men
	Nairobi	Mombasa	Kisumu	Mombasa
Do you approve of family planning?				
Yes	93.3	88.1	91.0	90.2
No	5.6	10.3	8.3	5.6
Don't know / missing	1.1	1.6	0.7	4.2
Total	100.0	100.0	100.0	100
Number of women	1,333	933	941	693

## Discussion and decision making on FP

Male and female survey respondents at baseline and mid-term reported whether they had ever discussed FP with their spouse. Respondents were asked about the frequency of discussions, who initiates these discussions and the need for consent from family members or providers prior to use of FP.

Regarding the frequency of FP discussion reported by women respondents, no changes occurred in Nairobi or Kisumu. In Mombasa, discussions became less frequent with about 5 percent of participants shifting from discussing FP more than twice in the past six months to only once or twice. Bigger changes were seen in reports on who initiated discussions. In both Nairobi and Kisumu, a larger share of women reported at mid-term that they are the ones to initiate discussion; far fewer women indicated at mid-term that they did not discuss FP at all. In Mombasa, a smaller percentage of women at mid-term reported needing someone's permission to use FP, compared with two years earlier. Approximately 40 percent of women in both Mombasa and Kisumu at mid-term reported that they need someone's permission to use FP. Among women that reported they need permission to use FP, more women at mid-term than at baseline in Nairobi and Mombasa reported needing permission from their healthcare provider in order to use FP.

**Table 6.3. Spousal communication among women**

Percent distribution of women by their spousal communication on topics of FP and fertility among women by city, at baseline and mid-term. Kenya, 2010, 2012.

	Nairobi		Mombasa		Kisumu	
	Baseline	Mid-term	Baseline	Mid-term	Baseline	Mid-term
<b>Women in Union</b>						
How often have you discussed FP in the last 6 months?	n = 1,466	n = 801	n = 832	n = 576	n = 986	n = 610
Not discussed in last 6 months	49.4	48.7	59.9	58.5	50.8	52.6
Once or twice	25.4	25.0	19.7	25.2	28.8	28.9
More than twice	25.2	26.4	20.3	16.3	20.4	18.5
Who usually initiates the discussion?	n = 1,440	n = 802	n = 827	n = 574	n = 952	n = 610
Self	30.0	51.9	31.3	35.5	39.2	50.0
Partner	16.4	18.4	13.6	10.6	15.3	14.1
Either	20.4	13.8	18.4	17.9	15.5	14.3
Neither / don't discuss FP	33.2	15.8	36.7	36.0	30.1	21.6
<b>All women</b>						
If you wanted to use a method of FP, would you need anyone's permission?	n = 2,706	n = 1,333	n = 1,465	n = 932	n = 1,603	n = 941
Yes	26.0	26.4	45.8	37.9	40.4	39.3
No	72.4	72.2	45.4	57.1	58.1	58.6
Don't know	1.2	1.1	8.3	4.8	1.5	2.0
Missing	0.4	0.3	0.5	0.2	0.1	0.0
Among those who need permission, from whom?	n = 700	n = 352	n = 671	n = 353	n = 647	n = 370
Husband	91.6	87.2	94.3	93.2	89.9	91.8
Other relative	8	5.4	5.4	8.1	13.3	10.5
HC provider	3	10.9	1	5.2	1.5	1.5

Note: Multiple responses could be given so percentages do not sum to 100%

Note: The small number of respondents with missing responses are not included in the indicator calculation

In Mombasa, more men reported having ever discussed FP with their spouse compared to women's reports (81 percent compared with 64 percent of women) and more than half of all men surveyed in either round of cross-sectional surveys reported having these discussions more than twice in the last six months (see Table 6.4). In comparison, only 16 percent of women in the same city reported similarly high levels of FP discussion. Although women surveyed reported that their spouse initiates FP discussion about 10 percent of the time, according to male reports in the separate cross-sectional surveys, they initiate approximately half of all discussions. The vast majority of men in Mombasa (90 percent) find discussions of family planning easy and nearly two thirds said that method use is jointly decided. According to male reports from the two rounds of cross-sectional surveys, discussions of desired fertility also appeared to be common (72 percent) and happened at least once in the last six months (75 percent).

**Table 6.4. Spousal communication among men**

Percent distribution of men by their spousal communication on topics of FP and fertility among men in Mombasa at mid-term. Kenya 2010, 2012.

	Mombasa	
	Baseline	Mid-term
<b>Men in Union</b>		
<b>Ever discussed FP with spouse</b>	n=301	n = 418
Yes	76.9	80.8
No	23.2	19.2
<b>If yes, how often have you discussed the subject in the last 6 months?</b>	n=232	n = 338
Not discussed in last 6 months	15.5	20.8
Once or twice	22.3	23.2
More than twice	62.3	56.0
<b>If yes, who initiates discussion about FP?</b>	n=232	n = 338
Self	22.4	46.8
Spouse	29.3	24.9
Both	48.4	28.3
<b>How difficult is it to start a conversation about family planning with your partner?</b>	n=301	n = 338
Very difficult	2.3	0.3
Somewhat difficult	7.7	10.2
Easy	90.1	89.5
<b>Have you discussed the number of children you would like to have with your spouse?</b>	n=301	n = 418
Yes	77.3	71.7
No	22.7	28.3
<b>If yes, how often have you discussed the subject in the last 6 months</b>	n=232	n = 299
Not discussed in last 6 months	21.2	25.2
Once or twice	20.5	27.2
More than twice	58.3	47.5
<b>Current FP users</b>		
<b>Who decides what type of method to use?</b>	n=250	n = 410
Mainly you	27.4	24.4
Mainly partner	15.5	13.8
Jointly	55.7	61.4
Other	1.4	0.4

Note: The small number of respondents with missing responses are not included in the indicator calculation

## Chapter 7. Demand generation

### Exposure to the Tupange program

Respondents at mid-term were asked a series of questions on their exposure to the Tupange program. Table 7.1 shows responses from the panel of women and the cross-section of men on their exposure to specific Tupange-branded logos and messages in the three intervention cities. Respondents were asked if they had heard or seen the word “Tupange” in the last year; they were then shown an A4-sized, laminated card with the Tupange logo on a white background. The Kiswahili translation of *tupange* is “let’s plan” or “we plan together”, therefore the sequence of the survey questions was designed to avoid confusion between the common meaning of *tupange* and having actually seen the Tupange program logo. Respondents that recognized the logo were asked where they saw it most recently. Responses included the most common areas a respondent might have seen the logo, including all media channels used by Tupange such as TV and radio as well as the various Tupange-produced promotional materials such as umbrellas and health worker uniforms. Recognition of both the Tupange name and the logo was high. In Nairobi and Mombasa, more women recognized the logo than knew the word (67 percent versus 64 percent in Nairobi, 64 percent versus 62 percent in Mombasa). The highest levels of recognition of the name and logo were in Kisumu, at about 75 percent. In Mombasa, men and women reported similar rates of recognition.

**Table 7.1. General exposure to the Tupange program**

Percent distribution of women and men by general exposure to the Tupange program by city, at mid-term. Kenya 2012.

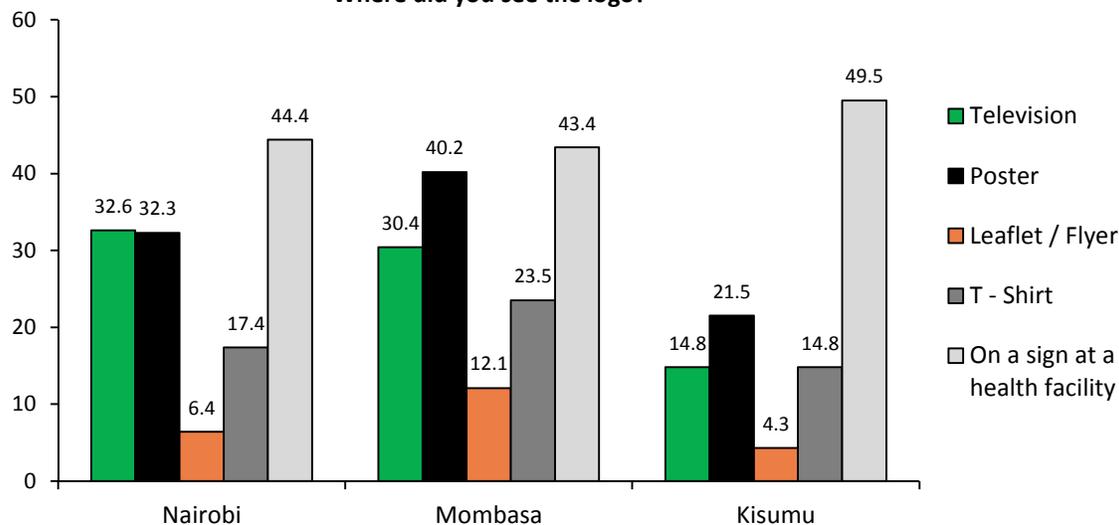
	Women			Men
	Nairobi	Mombasa	Kisumu	Mombasa
Have heard or seen the word "Tupange" in the past year	n = 1,333	n = 933	n = 941	n = 696
Yes	63.6	61.5	75.5	64.9
No	36.4	38.5	24.5	35.1
Have ever seen Tupange program logo	n = 1,333	n = 933	n = 941	n = 696
Yes	66.7	64.4	74.4	61.5
No	33.3	35.6	25.6	38.5
Where did you see this logo?	n = 886	n = 600	n = 699	n = 428
Television	32.6	30.4	14.8	28.2
Poster	32.3	40.2	21.5	31.8
Newsmagazine or booklet	3.2	4.9	1.0	9.2
Leaflet / flyer	6.4	12.1	4.3	3.6
Internet / Facebook	0.5	1.9	0.5	1.0
Umbrella	0.6	0.9	0.7	3.0
Calendar	0.4	6.2	0.2	5.7
T - Shirt	17.4	23.5	14.8	28.8
Health worker uniform / coat	8.7	6.9	4.6	4.2
On a sign at a health facility	44.4	43.4	49.5	34.7
On a street banner	5.0	7.4	6.0	3.8
Khanga / lesa	4.3	2.3	2.0	4.2
Other	2.5	3.8	7.0	10.3
Can't remember	4.1	2.7	4.8	5.5

Note: Multiple responses could be given so percentages do not sum to 100%

Note: The small number of respondents with missing responses are not included in the indicator calculation

Respondents could list multiple locations for where they had seen the logo; “on a sign at a health facility” was most frequently reported followed by posters and TV. However, TV exposure to the logo was lower in Kisumu (15 percent) compared to Mombasa (30 percent) and Nairobi (33 percent).

**Figure 7.1. Among women who reported seeing the Tupange logo:  
Where did you see the logo?**



### Exposure to Tupange outreach and interpersonal programs

Tupange designed demand generation, behavior change and communications (BCC) activities and materials to compliment in-reach activities (where teams of trained providers offered LAPMs at facilities that wouldn't normally offer them) and FP camps (pop-up facilities where LAPMs were offered). These special events offer FP services and LAPMs in locations or facilities where they are not normally provided. Community health workers (CHWs) wearing Tupange-branded shirts were trained on counseling and referral for FP (specifically focusing on LAPMs) and 'FP champions' were identified and trained to promote FP at various community forums. Respondents were asked if in the last year, they had attended a meeting about FP led by someone with a Tupange logo on their clothing (Table 7.2). In Kisumu, 17 percent of female respondents reported attending such a meeting; fewer respondents in Nairobi and Mombasa had attended such a meeting. Respondents were then asked if they had seen any FP or birth spacing information at other outreach activities Tupange supported. Caravan road-shows (slow-moving, open-top trailers with singers, dancers and music) were commonly cited among women and men, especially in Kisumu where almost 80 percent of female respondents reported seeing one. Community meetings which include chief's counsels or neighborhood meetings were also commonly reported by both men and women.

### Exposure to Tupange print materials

Table 7.3 shows the percentage of men and women who read newspapers or magazines in the last year, whether or not they reported seeing information about FP/birth spacing and whether they saw Tupange-specific print material. Overall, print readership is high; around 60 percent of female respondents reported reading a newspaper or magazine in the last year. Readership among men in Mombasa is higher, where almost 85 percent reported reading newspapers or magazines. Among female respondents, just under half reported seeing any FP/birth spacing information in the newspapers, which was higher than those that reported seeing Tupange-specific articles in the newspapers. Almost a quarter of men in Mombasa reported reading an article on FP/birth spacing that mentioned Tupange.

**Table 7.2. Exposure to outreach and interpersonal activity**

Percent distribution of women and men by exposure to Tupange interpersonal and outreach activities by city, at mid-term. Kenya 2012.

	Women			Men
	Nairobi	Mombasa	Kisumu	Mombasa
Have attended any meetings about FP / child birth spacing that were led by someone wearing any clothing with the Tupange logo in the past year	n = 1,333	n = 933	n = 941	n = 696
Yes	11.5	10.0	17.0	5.7
No	88.5	90.0	83.0	94.3
Heard any teenage pregnancy, relationship advice, male responsibility, or FP /child birth spacing messages from any of the following events in the last year	n = 1,333	n = 933	n = 941	n = 696
Caravan road-show event	38.1	33.1	78.8	23.2
Community meeting	29.4	21.2	32.9	22.8
Football competition	6.5	3.1	10.9	9.0
Beauty contest	7.4	4.5	8.6	2.8
Boda-Boda event	3.0	1.5	13.9	3.2
Public entertainment event	25.6	19.4	25.7	25.6
None	41.5	52.4	11.5	47.8

Note: Multiple responses could be given so percentages do not sum to 100%

At mid-term, respondents were asked about their exposure to Tupange printed materials. Tupange produced printed materials in three formats: 1) leaflets/brochures promoting FP and the benefits of a smaller family, 2) Tupange posters at health facilities, and 3) *Shujaaz*, a comic book distributed as an insert in the country's popular daily newspaper, *Daily Nation* and at M-PESA (mobile money transfer) kiosks. If the respondent reported seeing one of these items, they were then asked if they had discussed the item with anyone, and if so, with whom. Around a third of respondents overall reported seeing a leaflet, while reported discussion of the leaflet among those who saw it ranged from 24 percent in Nairobi to 44 percent in Mombasa (Table 7.3). A large percentage of men in Mombasa (31 percent) reported seeing a leaflet; 44 percent of those men who saw a leaflet also reported that they discussed it with others including their spouse and friends.

Posters bearing the Tupange logo and tagline *Imarisha Maisha* ("Celebrate life, Use Family Planning"), were distributed to health facilities and to CHWs to hand out during their meetings. In Nairobi and Mombasa, around 40 percent of women reported seeing a poster (42 percent and 45 percent, respectively); in Kisumu 52 percent of female respondents had seen these posters (Table 7.3).

*Shujaaz*, described above, means "heroes" in Sheng, the Kenyan youth slang. The comic follows the life of four young characters. Tupange worked with the producer of the comic to include program messages to youth on FP/RH, services available and where to find them. Among women that reported seeing any *Shujaaz* comic, approximately 60 percent reported seeing a comic with the Tupange-sponsored topics. In Mombasa, around half of the respondents that saw a Tupange-sponsored episode of *Shujaaz* reported discussing it with someone, most often among relatives and friends.

**Table 7.3. Exposure to Tupange print communications**

Percent distribution of women and men by exposure to Tupange print communications by city at mid-term. Kenya 2012.

	Women			Mombasa
	Nairobi	Mombasa	Kisumu	Men
Read newspapers / magazines in the last year	n = 1,333	n = 933	n = 941	n = 696
Yes	65.4	61.1	63.7	84.1
No	34.6	38.9	36.3	15.9
Read any articles on family planning/child birth spacing information in the last year	n = 1,333	n = 933	n = 941	n = 696
Yes	45.7	43.5	41.8	54.5
No	53.2	56.5	57.7	45.1
Don't know	1.1	0.1	0.4	0.4
Read any articles on family planning/child birth spacing information in the last year that talked about the Tupange Project	n = 1,333	n = 933	n = 941	n = 696
Yes	15.3	18.3	21.8	24.5
No	82.1	80.0	78.0	72.4
Don't know	2.6	1.7	0.2	3.1
Saw or read a brochure or leaflet with <i>Tupange, Imarisha Maisha</i> on it	n = 1,333	n = 933	n = 941	n = 696
Yes	31.3	35.5	39.1	30.5
No	68.7	64.5	60.9	69.5
Did you discuss this brochure/leaflet with anyone else?	n = 417	n = 332	n = 368	n = 212
Yes	24.4	44.1	35.1	43.9
No	75.6	55.9	64.9	56.1
If yes, with whom?	n = 102	n = 146	n = 129	n = 93
Spouse / partner	11.5	22.0	11.8	46.1
Relative	14.1	28.0	22.8	10.1
Friend	73.8	59.9	54.1	63.8
Health worker	10.5	7.0	4.0	17.3
Community leader	4.4	4.3	1.5	3.8
Saw or read a poster with Tupange or "Celebrate Life!, Use Family Planning"	n = 1,333	n = 933	n = 941	n = 696
Yes	42.2	44.5	51.5	32.6
No	57.8	55.5	48.5	67.4
Did you discuss this poster with anyone else?	n = 561	n = 414	n = 485	n = 227
Yes	17.7	30.2	26.3	31.2
No	82.3	69.8	73.7	68.8
If yes, with whom?	n = 99	n = 124	n = 127	n = 71
Spouse / partner	4.6	18.2	10.8	43.1
Relative	10.6	28.1	22.9	4.2
Friend	84.2	61.8	59.6	63.6
Health worker	6.6	6.0	6.4	17.4
Community leader	0.5	5.1	1.5	1.7
Have you seen or heard of the Shujaaz comic book?	n = 1,333	n = 933	n = 941	n = 696
Yes	26.1	35.7	25.8	35.5
No	73.9	64.3	74.2	64.5
Have you read or seen a Shujaaz comic book about teenage pregnancy, or relationships, or male responsibility	n = 348	n = 333	n = 242	n = 247
Yes	60.3	60.3	58.9	61.5
No	39.7	39.7	41.1	38.5
Did you discuss this comic with anyone else?	n = 210	n = 201	n = 143	n = 152
Yes	22.9	46.2	32.7	53.1
No	77.1	53.8	67.3	46.9
If yes, with whom?	n = 48	n = 93	n = 47	n = 81
Spouse / partner	6.9	5.4	6.7	9.2
Relative	28.3	49.3	36.3	5.4
Friend	74.5	71.0	64.6	91.2
Health worker	1.0	4.1	0.0	0.0
Community leader	0.4	0.0	0.0	0.0

Note: Multiple responses could be given so percentages do not sum to 100%

Note: The small number of respondents with missing responses are not included in the indicator calculation

## Exposure to Tupange radio programs

Radio listenership is high in Kenya; between 80 and 90 percent of female respondents reported listening to the radio at least occasionally. Among men in Mombasa, radio listenership is almost universal. A large percentage of male and female respondents (more than 65 percent of women, and 80 percent of men) reported hearing a family planning/birth spacing message on the radio in the past year (Table 7.4). Tupange worked with a local NGO to produce several episodes of a radio drama called *Jongo Love*. Primarily aimed at a young audience, it follows several characters as they negotiate real-life situations involving decision-making around sex, relationships and other RH topics. Between 14 and 22 of women reported having heard the *Jongo Love* program, respectively in Mombasa and Kisumu. Among those that heard the program, 15 to 30 percent had discussed the program with someone else, with the highest percent in Mombasa.

**Table 7.4. Exposure to Tupange radio programs**

Percent distribution of women and men by exposure to Tupange radio programs by city at mid-term. Kenya 2012.

	Women			Men
	Nairobi	Mombasa	Kisumu	Mombasa
How often do you listen to the radio?	n = 1,333	n = 933	n = 941	n = 696
Every day	66.2	48.1	60.6	76.4
At least once a week	17.8	23.2	22.0	17.7
At least once in two weeks	3.3	7.5	5.0	3.6
Not at all	12.8	21.2	12.4	2.4
Heard any family planning/child birth spacing information on the radio in the past three months	n = 1,333	n = 933	n = 941	n = 679
Yes	71.9	65.1	79.9	80.5
No	28.1	34.9	20.1	19.5
Have heard and/or listened to the Tupange radio program "Jongo Love"	n = 1,333	n = 933	n = 941	n = 679
Yes	16.7	13.7	21.6	24.7
No	83.3	86.3	78.4	75.3
Did you discuss this radio program with anyone else?	n = 221	n = 125	n = 204	n = 168
Yes	14.9	29.6	21.2	18.9
No	85.1	70.4	78.8	81.1
If yes, with whom?	n = 33	n = 37	n = 43	n = 32
Spouse / partner	26.4	16.4	17.0	59.0
Relative	16.2	41.4	8.6	9.3
Friend	60.6	48.6	74.5	67.3
Health worker	0.0	0.0	0.0	0.0
Community leader	0.0	0.0	0.0	0.0

Note: Multiple responses could be given so percentages do not sum to 100%

Note: The small number of respondents with missing responses are not included in the indicator calculation

## Exposure to Tupange television programs

Results on TV viewership and the percentage of respondents that had seen the Tupange-sponsored TV programs are presented in Table 7.5. TV viewership was highest in Nairobi, with 74 percent that reported watching TV at least once a day, followed by Mombasa (63 percent) and Kisumu (57 percent). About 63 percent of men in Mombasa watch TV at least once a day.

**Table 7.5. Exposure to Tupange TV programs**

Percent distribution of women and men by exposure to Tupange TV programs by city, at mid-term. Kenya 2012.

	Women			Men
	Nairobi	Mombasa	Kisumu	Mombasa
How often do you watch TV?	n = 1,333	n = 933	n = 941	n = 696
Every day	74.0	63.0	57.3	62.8
At least once a week	11.9	11.9	13.8	27.2
At least once in two weeks	3.6	5.2	6.7	3.6
Not at all	10.5	19.9	22.1	6.5
Seen any family planning/child birth spacing information on TV in the past three months	n = 1,333	n = 933	n = 941	n = 648
Yes	77.3	64.8	68.9	74.6
No	22.7	35.2	31.1	25.4
Recognized scenes from TV program Matatu	n = 1,333	n = 933	n = 941	n = 651
Yes	58.3	27.3	31.3	37.1
No	41.7	72.7	68.7	62.9
What were the key topics or information carried by the show?	n = 777	n = 253	n = 293	n = 242
Benefits of FP	21.5	45.8	53.4	42.0
Role of men in FP	7.8	3.9	6.3	10.6
An ideal quality of life	9.7	13.9	4.9	4.5
Myths around FP	3.1	2.1	2.9	9.9
Being in an abusive relationship	3.6	5.9	2.6	9.1
Overcome an abusive relationship	2	1.6	0.4	8.4
Gender based violence and rape	6.4	0.7	1.3	5.2
Teenage pregnancy	14.5	7.3	7.2	13.3
Cash for births	0	0.7	0	9.1
Negative statements about FP	5.1	2.9	2.5	3.9
Don't know	38.6	36.7	26.5	21.8
Did you discuss this TV program with anyone else?	n = 777	n = 255	n = 294	n = 242
Yes	9.7	18.9	20.1	24.9
No	90.3	81.1	79.9	75.1
If so, with whom?	n = 75	n = 48	n = 59	n = 60
Spouse / partner	25.6	13.8	21.2	55.8
Relative	20.3	51.0	22.0	9.6
Friend	63.9	33.7	56.2	52.6
Health worker	1.0	0.7	2.1	2.0
Community leader	0.0	0.0	0.0	0.0

Note: Multiple responses could be given so percentages do not sum to 100%

Note: The small number of respondents with missing responses are not included in the indicator calculation

Tupange sponsored two episodes of a TV program called *Matatu*, filmed on the mini-buses, matatus, that form the backbone of public transit in Kenya. The show takes place inside a matatu, which gives a free ride to passengers in exchange for them being part of a small group discussion on different topics. For the Tupange episodes, the topics revolved around FP and family size. At mid-term, survey respondents were asked if they recognized a still photo from the show, which was presented on an A4-sized color printout. Recognition of the show was highest in Nairobi, with almost 60 percent of women recognizing the program. About 37 percent of men in Mombasa recognized the program from the still photo. Respondents were also asked to identify the key components of the show, since there were episodes that did not deal with FP/RH issues. Despite lower recognition of the show (27 percent in Kisumu, 31 percent in Mombasa, 58 percent in Nairobi), respondents in Kisumu and Mombasa reported the topic “benefits of FP” more frequently than those in Nairobi (46 percent and 53 percent, compared to 22 percent respectively). Among men in Mombasa that recognized the program, 42 percent mentioned “benefits of FP” was a key topic on the show. Between 22 and 39 percent of respondents that recognized the show did not remember what the key topics were.

### **Exposure to Tupange internet programs**

Overall, internet use is highest among men in Mombasa (43 percent) followed by women in Nairobi (31 percent) and women in Mombasa (27 percent) (Table 7.6). Among those that had accessed the internet in the past year, around half reported at least daily usage. Tupange used a number of internet resources as part of their demand generation activities. The most common were YouTube and Facebook sites that were linked to the radio and comic book programs (*Jongo Love* and *Shujaaz*). Among women that had accessed the internet in the last year, 45 percent in Nairobi reported seeing a FP-related message on Facebook, compared to 31 percent in Mombasa and 39 percent in Kisumu. However, a large percentage of women in each city (34 percent, 44 percent and 39 percent respectively) reported they had not seen any FP-related messages on the internet. Compared to the other media sources, discussion of the internet-based media messages was relatively high; 47 percent of women in Kisumu that saw a message reported discussing it afterwards.

**Table 7.6. Exposure to Tupange internet programs**

Percent distribution of women and men by exposure to Tupange internet programs by city, at mid-term. Kenya 2012.

	Women			Men
	Nairobi	Mombasa	Kisumu	Mombasa
Accessed internet in past year	n = 1,333	n = 933	n = 941	n = 696
Yes	30.7	27.4	22.3	43.0
No	66.7	63.7	72.1	53.0
Don't know internet, web, email	2.6	8.9	5.5	4.0
How often do you access internet, web or email (among those that accessed internet in last year)	n = 409	n = 255	n = 209	n = 297
Every day	49.9	43.6	45.7	57.8
At least once a week	32.4	35.0	30.3	35.1
At least once in two weeks	8.6	11.0	11.0	3.6
Less frequently	9.1	10.4	13.0	3.5
Seen any teenage pregnancy, male responsibility, or relationship advice on the internet in past year, from following sources (among those that access the internet)	n = 409	n = 255	n = 210	n = 297
Have not seen these messages on internet	33.9	44.1	39.1	62.1
Facebook	44.8	30.9	39.2	26.2
YouTube	18.3	11.5	13.9	6.1
Tupange / Youth Smart website	5.8	4.1	2	2.3
Shujaaz website	3.2	1.2	1.9	0.8
Shujaaz Facebook page	2.8	1.9	2	1.1
Jongo Love website	2.2	0.4	1.4	0.1
None of these - another site	27.6	22.3	20.8	15.5
Did you discuss this media source with anyone else?	n = 269	n = 143	n = 128	n = 111
Yes	42.6	40.9	46.9	35.9
No	57.4	59.1	53.1	64.1
If so, with whom?	n = 115	n = 58	n = 60	n = 40
Spouse / partner	15.0	12.5	14.0	19.4
Relative	16.5	26.5	6.7	0.7
Friend	75.7	90.3	75.9	81.5
Health worker	3.3	2.2	0.0	3.0
Community leader	0.0	0.0	0.0	0.0

Note: Multiple responses could be given so percentages do not sum to 100%

Note: The small number of respondents with missing responses are not included in the indicator calculation

## Chapter 8. Service delivery point survey

Fifteen public and private facilities included in baseline data collection in Kisumu in 2011 were surveyed again at mid-term in 2012. All 15 of the facilities surveyed at both baseline and mid-term are located in Kisumu East District and are supported by the Tupange project. Data were collected at both time periods using identical instruments: a facility audit and questionnaires for interviewing both FP service providers and exiting FP clients. An extensive facility audit was conducted in each of the 15 participating facilities in collaboration with the facility supervisor. This chapter presents findings on method availability, physical infrastructure, characteristics of FP clients and providers, quality of FP service provision and client exposure to messages about FP.

### Facility service statistics

#### *Method provision and availability*

Data on provision and availability of specific methods as well as occurrence of stock-outs are presented in Table 8.1. At both baseline and mid-term, the majority of facilities reported provision of short-acting methods such as pills, condoms, E-pill and injectables. Provision of LAPMs was less common at baseline with half or fewer of the 15 facilities providing implants, IUDs and male or female sterilization. By mid-term, provision of long-acting methods including implants and IUDs had increased to 100 percent and the percent of facilities providing sterilization services for men or women had increased to nearly half of the facilities. In addition to general method provision, increases were also seen in the current availability of methods. For example, current availability of male condoms increased from 80 to 100 percent. Injectables and IUDs also increased their current availability to 100 percent of the 15 facilities. Lastly, reductions were seen in the percent of facilities experiencing method-specific stock-outs over the previous 12 months, across all methods except E-pills. Most notably, several more facilities at mid-term did not experience stock-outs of male condoms, injectables and IUDs over the previous year, compared to baseline.

**Table 8.1. FP method provision and availability**

Percent distribution of facilities providing specific FP methods, with methods currently available, and without method stock-out in the previous 12 months at baseline and mid-term. Kenya 2011, 2012.

	Percent of facilities providing each method		Percent of facilities providing each method, with method currently available		Percent of facilities providing each method, without stock-out in last year	
	Baseline	Mid-term	Baseline	Mid-term	Baseline	Mid-term
Combined oral contraceptive	(n=15) 100.0	(n=15) 100.0	(n=15) 100.0	(n=15) 100.0	(n=15) 93.3	(n=15) 100.0
Progestin only pill	(n=15) 100.0	(n=15) 100.0	(n=15) 100.0	(n=15) 100.0	(n=15) 86.7	(n=15) 100.0
E-pill	(n=15) 100.0	(n=15) 100.0	(n=15) 86.7	(n=15) 73.3	(n=15) 80.0	(n=15) 46.7
Male condom	(n=15) 100.0	(n=15) 100.0	(n=15) 80.0	(n=15) 100.0	(n=15) 40.0	(n=15) 80.0
Female condom	(n=15) 66.7	(n=15) 100.0	(n=10) 80.0	(n=15) 86.7	(n=10) 60.0	(n=15) 66.7
Injectables	(n=15) 100.0	(n=15) 100.0	(n=15) 86.7	(n=15) 100.0	(n=15) 46.7	(n=15) 86.7
Implants	(n=15) 46.7	(n=15) 100.0	(n=7) 100.0	(n=15) 100.0	(n=7) 85.7	(n=15) 93.3
IUD	(n=15) 53.3	(n=15) 100.0	(n=8) 87.5	(n=15) 100.0	(n=8) 75.0	(n=15) 100.0
Postpartum IUD	(n=15) 40.0	(n=15) 73.3	N/A	N/A	N/A	N/A
Female sterilization	(n=15) 26.7	(n=15) 40.0	N/A	N/A	N/A	N/A
Male sterilization	(n=15) 20.0	(n=15) 46.7	N/A	N/A	N/A	N/A
Traditional family planning*	(n=15) 33.3	(n=15) 100.0	N/A	N/A	N/A	N/A

Note: Data on stockouts of injectables and IUDs is missing for one facility which is not included in the indicator calculation

\* Traditional family planning methods include periodic abstinence and withdrawal, and natural methods such as standard days / safe days / cycle beads

**Physical infrastructure**

In Table 8.2, data are presented on the availability of specific guidelines and select aspects of the facilities' physical infrastructure. One or more facilities experienced an increase in the presence of a quality assurance committee, written FP protocols and guidelines or tools to screen for pregnancy. At mid-term, more facilities reported availability of a functioning sterilizer, sealed implant packs and sterile gloves, yet two facilities no longer reported availability of a private exam room. Other types of physical infrastructure, including electricity, running water and hand soap remained the same across facilities at both time periods.

**Table 8.2. Physical infrastructure to support FP provision**

Percent distribution of facilities with select guidelines, tools, and physical infrastructure at baseline and mid-term. Kenya 2011, 2012.

	Baseline	Mid-term
Is there any type of quality assurance committee or staff meetings?	33.3	60.0
Are there any written guidelines or protocols for FP in this facility?	73.3	86.7
Are you using any guidelines or tools to screen patients for pregnancy?	80.0	86.7
Does this facility have the following, available and functioning?		
Availability and functionality of electricity	93.3	93.3
Availability and functionality of running water	66.7	66.7
Availability and functionality of private exam room	80.0	66.7
Availability and functionality of sterilizer	66.7	80.0
Availability of sealed implant packs	46.7	93.3
Availability and functionality of hand washing soap	80.0	80.0
Availability and functionality of sterile gloves	66.7	93.3

## Demographic characteristics of FP clients and providers

### FP clients

Demographic characteristics of FP clients attending the 15 surveyed facilities are presented in Table 8.3. FP clients had very similar characteristics at baseline and mid-term with respect to age, parity, religion and education. The majority of clients were married, Protestant, had attended primary or secondary school and were around 26 years of age with two to three children. One notable change was the marital status of the average client. While at baseline 13 percent of clients of these facilities had never been married, this number grew to 22 percent by mid-term, indicating that these facilities were reaching more single women at mid-term compared to baseline.

**Table 8.3. Demographic characteristics of FP clients and providers**

Mean age and parity, and percent distribution of FP clients by religion, education, and marital status; mean age and years of professional experience, and percent distribution of FP providers by religion and gender at baseline and mid-term. Kenya 2011, 2012.

	Clients		Providers	
	Baseline (n=160)	Mid-term (n=140)	Baseline (n=44)	Mid-term (n=93)
Mean age	25.0	26.7	35.8	36.6
Mean parity	2.4	2.6	N/A	N/A
Mean number of years working as a health care provider	N/A	N/A	9.3	11.0
Religion				
Christian, Catholic	32.5	23.6	20.5	28.0
Protestant/other Christian	61.9	75.0	77.3	69.9
Muslim	1.9	1.4	2.3	2.2
Traditional	3.1	0.0	0.0	0.0
No Religion	0.6	0.0	0.0	0.0
Gender				
Male	N/A	N/A	20.5	18.3
Female	N/A	N/A	79.5	81.7
Education				
Never attended school	1.9	0.7	N/A	N/A
Attended primary	51.3	45.7	N/A	N/A
Attended secondary/A level	33.8	33.6	N/A	N/A
Attended college (middle level)	11.9	16.4	N/A	N/A
Attended university	1.3	3.6	N/A	N/A
Marital status				
Currently married	81.9	71.4	N/A	N/A
Living with a man as if married	0.6	1.4	N/A	N/A
Divorced or separated	1.3	2.9	N/A	N/A
Widowed	3.1	2.1	N/A	N/A
Single, never married	13.1	22.1	N/A	N/A

Note: Exit interviews were not conducted at one facility at baseline; client indicators are calculated for 14 facilities

### FP providers

Table 8.3 also contains characteristics of FP providers; these characteristics were unchanged over the one year time period. FP providers at the 15 participating facilities were most likely to be female and Protestant. On average, providers were 36 years of age and had 9 to 11 years of experience as a health care provider.

### Quality of FP service delivery

A formal framework, developed by The Population Council in 1990, outlines several essential elements of quality in FP service delivery (Bruce 1990). This section will report on five of these elements, using data collected from FP clients and providers: choice of methods, information given to clients, interpersonal relations, provider competence, and follow-up mechanisms.

### FP clients report on quality

Data gathered from interviews with FP clients are shown in Table 8.4. Regarding choice, a higher percentage of new FP clients at mid-term reported that their provider inquired about their preferred method (from 63 to 91 percent) and discussed a range of methods during their counseling session (from 49 to 78 percent). According to client reports, at mid-term a greater percentage of providers asked about preferred methods among continuing clients (from 45 to 65 percent). Regarding information provided to new and switching clients, the percent that reported receiving information on correct method use, possible side effects and management of health problems nearly doubled between baseline and mid-term. Little change was seen among continuing clients with respect to information and little improvement between baseline and mid-term was seen in the percent of providers asking clients about their reproductive goals. Lastly, with respect to follow-up mechanisms, a slight drop (from 94 to 83 percent) was seen in the percent of providers telling new clients when to return for method continuation.

**Table 8.4. Client reports of select aspects of quality of FP service delivery**

Percent distribution of new and continuing FP clients reporting on select aspects of FP service quality at baseline and mid-term. Kenya 2011, 2012.

	New clients		Continuing clients	
	Baseline	Mid-term	Baseline	Mid-term
Choice of methods	(n=35) <sup>1</sup>	(n=45) <sup>1</sup>	(n=125)	(n=95)
Provider offered information about different FP methods	48.6	77.8	41.6	31.6
Provider asked the client about her preferred method/method of choice	62.9	91.1	44.8	65.3
Information given to clients	(n=52) <sup>2</sup>	(n=59) <sup>2</sup>	(n=125)	(n=95)
Provider helped client select a method	42.3	44.1	N/A	N/A
Provider explained how to use the selected method	44.2	81.4	N/A	N/A
Provider talked about possible side effects	44.2	79.7	36.8	40.0
Provider asked the client about any problems she was having	N/A	N/A	60.8	71.6
Provider told the client what to do if she has any problems	48.1	78.0	48.0	51.6
Client-provider relations	(n=35) <sup>1</sup>	(n=45) <sup>1</sup>	(n=125)	(n=95)
Provider asked the client about her reproductive goals or plans	51.4	62.2	37.6	40.0
Follow-up mechanisms	(n=52) <sup>2</sup>	(n=59) <sup>2</sup>	(n=125)	(n=95)
Provider told the client when to return for follow-up	94.2	83.1	N/A	N/A

<sup>1</sup> New clients only

<sup>2</sup> New and switching clients

Note: Exit interviews were not conducted at one facility at baseline; client indicators are calculated for 14 facilities

Note: The small number of providers with missing responses are not included in the indicator calculation

*FP providers report on quality*

Results from FP providers are displayed in Table 8.5. At both baseline and mid-term, FP service providers reported nearly universal provision of information to clients on a range of FP methods; however, far fewer (69 percent at baseline and 56 percent at mid-term) reported asking the client which method she prefers to use. At both baseline and mid-term, the majority of service providers reported that they helped clients select an appropriate method and discussed possible side effects. Surprisingly, the percent of providers that offered instructions on correct method use and discussed potential warning signs associated with the selected method (around two thirds at baseline) decreased between 2011 and 2012. Only around 41 percent of providers interviewed at mid-term reported explaining proper method use to clients and only about 22 percent reportedly discussed medical reasons to return to the facility. At both time periods, less than half of providers reported inquiring about the reproductive goals of their clients. Regarding technical competence, in-service training on FP counseling remained high for both time periods and an increase was seen in the percent of providers that received in-service training on the provision of specific methods of FP. Lastly, while baseline data is not available on the percent of providers that report discussing with clients when they should return to the facility in order to maintain their method, approximately two thirds of providers at mid-term reported doing so.

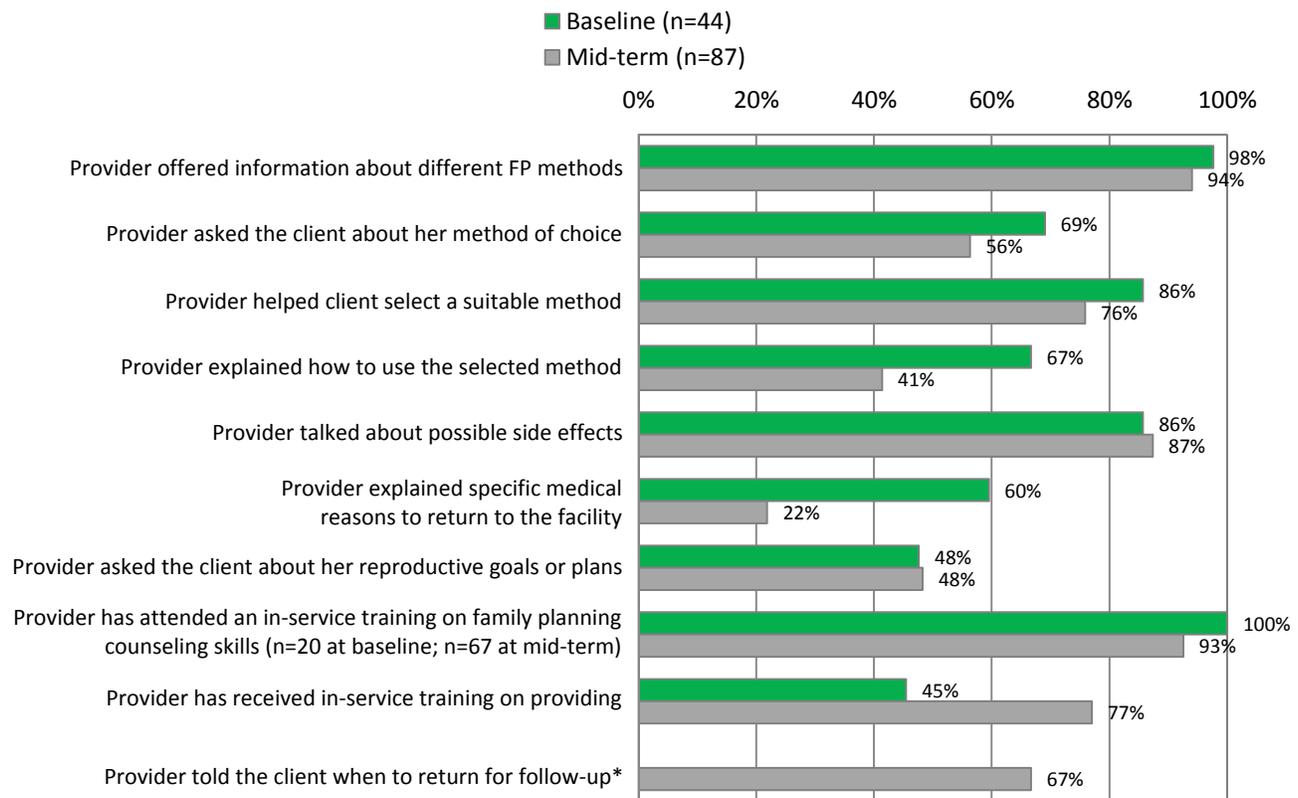
**Table 8.5. Provider reports of select aspects of quality of FP service**

Percent distribution of FP providers reporting on select aspects of FP service quality at baseline and midterm. Kenya 2011, 2012.

	Baseline (n=44)	Mid-term (n=87)
Choice of methods	(n=42)	(n=87)
Provider offered information about different FP methods	97.6	94.3
Provider asked the client about her method of choice	69.0	56.3
Information given to clients	(n=42)	(n=87)
Provider helped client select a suitable method	85.7	75.9
Provider explained how to use the selected method	66.7	41.4
Provider talked about possible side effects	85.7	87.4
Provider explained specific medical reasons to return to the facility	59.5	21.8
Client-provider relations	(n=42)	(n=87)
Provider asked the client about her reproductive goals or plans	47.6	48.3
Technical competence/training	(n=20)	(n=67)
Provider has attended an in-service training on family planning counseling skills	100.0	92.5
Provider has received in-service training on providing method(s) of family planning	(n=44) 45.5	(n=87) 77.0
Follow-up mechanisms	N/A	(n=87)
Provider told the client when to return for follow-up	N/A	66.7

Note: The small number of providers with missing responses are not included in the indicator calculation

**Figure 8.1 Provider reports of select aspects of quality of FP service delivery**



\*Note: Baseline data not available for 'Provider told the client when to return for follow-up'

### FP client satisfaction

Client satisfaction at baseline was high for nearly all indicators, as seen in Table 8.6, with the vast majority of clients reporting that they were treated well, received sufficient information, were satisfied with services, felt comfortable asking questions and will use the facility again. Approximately 79 percent of clients at baseline and 73 percent at mid-term felt that the wait time was appropriate and believed the provider will keep their information confidential. The only indicator of client satisfaction to change substantially by mid-term was whether the client felt she received enough information, which decreased from 95 percent at baseline to 84 at mid-term.

**Table 8.6. Client reports of satisfaction with select aspects of FP service delivery**

Percent distribution of FP clients reporting on select aspects of client satisfaction at baseline and mid-term. Kenya 2011, 2012.

	Baseline (n=160)	Mid-term (n=140)
Client Satisfaction		
Client felt she was treated well or very well by her provider	98.8	95.7
Client did not feel wait time was too long	79.4	72.9
Client believes information will be kept confidential	81.3	86.4
Client felt comfortable asking questions	92.5	92.1
Client felt she was given enough information	95.0	83.6
Client was at least somewhat satisfied with services	99.4	97.1
Client will use the facility again	99.4	94.3

Note: Exit interviews were not conducted at one facility at baseline; indicators are calculated for 14 facilities

### Exposure to FP messages

Table 8.7 presents data on exposure to FP messages from a variety of sources. At mid-term, 75 percent reported exposure to messages related to FP services. The majority of the FP messages were received through media sources including radio and television, and the percent of clients reportedly seeing FP messages in leaflets or flyers increased from 4 to 14 percent. A higher percentage of clients at mid-term also heard FP messages from health personnel, notably nurses and midwives (from 8 to 24 percent), community health workers (5 to 20 percent) and clinic staff (18 to 28 percent). A very large increase was seen in the percent hearing FP messages at community outreach events (from 16 to 65 percent) and also a modest increase among women's groups (from 6 to 18 percent). Friends and neighbors were also a notable source at mid-term, increasing from 34 to 50 percent.

**Table 8.7. Exposure to FP messages among exiting FP clients**

Percent distribution of FP clients reporting on exposure to FP messages at baseline and midterm. Kenya 2011, 2012.

	Baseline (n=160)	Mid-term (n=140)
Client has heard any family planning messages in the last 3 months	80.0	75.0
Client heard family planning message from:	(n=128)	(n=105)
<b>Media Sources</b>		
Radio	67.2	74.3
Television	25.8	25.7
Videos	0.8	0.0
Newspapers	3.1	4.8
Magazines/books	3.9	2.9
Flyers/leaflets	3.9	14.3
Billboards	0.8	6.7
Wall painting	0.0	1.9
Facebook	0.8	0.0
Internet	2.3	5.7
SMS	0.0	1.0
<b>Health Personnel Sources</b>		
Clinical officer/doctor	2.3	1.0
Nurse/midwife	7.8	23.8
CHW/CBD	4.7	20.0
Pharmacy/pharmacist	0.8	0.0
Chemist/Duka la Dawa	1.6	0.0
Hospital	37.5	5.7
Clinic	18.0	27.6
Traditional birth attendant	0.0	1.9
<b>Community Sources</b>		
Cinema/mobile cinema	0.0	0.0
Video Shops/den	0.0	1.0
Social/community halls	1.6	1.9
Community outreach events	15.6	64.8
Peer Education	0.8	1.0
School	2.3	2.9
NGOs	2.3	0.0
FBOs/church/mosques	0.0	1.9
Community meetings	2.3	4.8
Women's groups	6.3	18.1
<b>Interpersonal Sources</b>		
Parents	7.8	4.8
In-laws	3.1	1.9
Spouse/partner	2.3	9.5
Siblings	0.8	3.8
Sister/brother-in-laws	5.5	1.0
Friends/neighbors	33.6	49.5
Other relative	3.1	0.0

Note: Exit interviews were not conducted at one facility at baseline; indicators are calculated for 14 facilities

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## Appendix 1.

### Changes in contraceptive use by method and city at baseline and mid-term

Percent distribution of all women by contraceptive method currently used, among women interviewed at baseline and mid-term, by city. Kenya 2010, 2012.

Method	Nairobi			Mombasa			Kisumu			Total		
	Baseline	Mid-term	P-value of the difference	Baseline	Mid-term	P-value of the difference	Baseline	Mid-term	P-value of the difference	Baseline	Mid-term	P-value of the difference
<b>Any method</b>	48.9	55.9	0.007	34.2	43.5	0.002	50.5	60.6	0.000	45.9	53.5	0.000
<b>Any modern method</b>	45.1	48.3	0.188	30.2	34.2	0.136	46.5	55.5	0.000	42.0	45.7	0.053
<b>LAPM<sup>1</sup></b>	6.6	12.2	0.000	[3.8]	8.9	0.002	8.6	20.2	0.000	6.1	11.9	0.000
<b>Female/male sterilization</b>	[1.5]	[2.6]	0.011	[1.1]	[1.6]	0.309	[2.3]	[3.2]	0.010	1.5	2.4	0.004
<b>Daily pills</b>	12.1	9.2	0.185	6.8	[4.1]	0.066	[5.4]	[5.0]	0.623	10.7	7.9	0.099
<b>IUD</b>	[2.6]	[3.0]	0.534	[1.2]	[0.9]	0.720	[1.3]	[1.4]	0.791	2.2	2.4	0.641
<b>Injectables</b>	18.1	18.8	0.760	14.0	14.9	0.671	22.8	19.1	0.048	17.5	18.0	0.775
<b>Male condom</b>	6.8	7.1	0.875	[4.3]	[4.7]	0.734	8.6	10.0	0.314	6.4	6.7	0.774
<b>Implant</b>	[2.5]	6.6	0.000	[1.5]	6.4	0.000	[5.0]	15.7	0.000	2.4	7.0	0.000
<b>Other modern method<sup>2</sup></b>	[1.4]	[1.1]	0.557	[1.4]	[1.7]	0.763	[1.2]	[1.2]	0.925	[1.4]	[1.2]	0.703
<b>Any traditional method<sup>3</sup></b>	3.8	7.6	0.001	[4.0]	9.3	0.001	[3.9]	5.1	0.402	3.8	7.8	0.000
<b>Not using</b>	51.1	44.1	0.007	65.8	56.5	0.002	49.5	39.4	0.000	54.1	46.5	0.000
<b>Number of women</b>	1,333	1,333		933	933		941	941		3,207	3,207	

1 IUD, implants, male & female sterilization

2 Other modern methods include female condom, LAM/breastfeeding and E-Pill

3 Traditional methods include periodic abstinence, withdrawal, and standard days/safe days/cycle beads

Note: Numbers in brackets are based on less than 50 unweighted cases

Note: Baseline estimates include women successfully interviewed at baseline and mid-term only