

ORIGINAL RESEARCH ARTICLE

Factors that Influence Male Involvement in Sexual and Reproductive Health in Western Kenya: A Qualitative Study

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Abstract

This study explored factors that influence male involvement in reproductive health in western Kenya. Qualitative study design was used. From December 2008 to February 2009, data were collected via in-depth interviews and focus group discussions (FGDs) at three provinces of western Kenya. Twelve in-depth interviews and eight FGDs were conducted. Five participants in in-depth interviews were female, seven were male. Four of the FGDs had all-male participants, four all-female. The factors that influence male involvement in reproductive health emerged in two themes, namely gender norms and the traditional approaches used to implement reproductive health and family planning programs. Any strategy taken to involve men in reproductive health must therefore consider addressing these two factors. A review of the traditional approaches of implementing reproductive health is necessary to make them more male-friendly (*Afr J Reprod Health 2010; 14[4]: 33-43*).

Résumé

Facteurs qui influent sur le rôle du mâle dans la santé de reproduction et sexuelle à l'ouest de Kenya : une étude qualitative. Cette étude a exploré les facteurs qui influent sur le rôle du mâle dans la santé de reproduction à l'ouest du Kenya. On a employé l'organisation d'une étude qualitative. A partir du mois de décembre 2008 jusqu'au février 2009, nous avons recueilli des données à travers des interviews en profondeur et les discussions à groupe cible (DGC) dans trois provinces du Kenya de l'ouest. Nous avons recueilli douze interviews en profondeur et avons organisé huit DGCs. Parmi les participants aux interviews en profondeur, cinq étaient des femmes, sept étaient des mâles. Quatre parmi les DGCs étaient composés entièrement de mâles et quatre étaient composés entièrement de femmes. Les facteurs qui influent sur la participation des mâles à la santé de reproduction ont émergé en deux thèmes : 1) les normes du genre et 2) les approches traditionnelles dont on se sert pour mettre en œuvre les programmes de santé de reproduction et de planification familiale. Toute stratégie adoptée pour assurer la participation des hommes à la santé de reproduction doit donc penser à s'occuper de ces deux facteurs. Une révision des approches traditionnelles de la mise en application de santé de la reproduction est nécessaire pour les rendre plus favorables aux hommes (*Afr J Reprod Health 2010; 14[4]: 33-43*).

Keywords: Gender, male involvement, reproductive health, Kenya

Introduction

This paper presents some of the findings from a qualitative study whose main purpose was to explore the best strategies for involving men in reproductive health programs at facilities run by a group of health providers in the post-abortion care network (PACNET) of western Kenya. The providers within the PACNET are trained on post-abortion care and other reproductive health issues by a local nongovernmental organization, Kisumu Medical and Education Trust (K-MET). K-MET's programs complement the government's efforts to expand opportunities for community-based comprehensive reproductive health (RH) care in western Kenya. PACNET was created by the providers for professional interaction, regular updates, support, and networking on reproductive health issues. The PACNET providers implement

comprehensive reproductive health services at private and public health facilities in western Kenya.

Traditional reproductive health programs focus almost exclusively on women. Reproductive health services are commonly offered at clinics that have limited services for men and are frequented mostly by women¹. Programs dealing with family planning (FP), prevention of unwanted pregnancy and unsafe abortion, and the promotion of safe motherhood view women as their primary clients. One popular view holds that men know little about contraception, do not want their partners to use it, and are not interested in planning their families². Men are perceived as gatekeepers who not only restrict their partner's and children's access to health services but also neglect and abuse their partners, thereby contributing to poor health outcomes^{3,4}.

FP programs target mostly women for other reasons too. Reproductive health is considered the domain of

women; they are the ones who become pregnant, most contraceptive methods are designed for them, reproductive health services can be offered conveniently as part of maternal and child health services, and women need privacy and autonomy in reproductive health matters^{2,5}.

Increasingly, however, the belief that men should be involved in sexual and reproductive health has gained momentum. In recent years, efforts in many countries have sought to broaden men's responsibility for their own reproductive health as well as that of their partners^{4,5,6,7}. The focus on reproductive health programs involving men received heightened attention at the 1994 Cairo International Conference on Population and Development (ICPD)⁸. The HIV pandemic has also made it crucial that men participate in reproductive health issues^{5,9}.

Studies have shown that men usually do want to be involved in reproductive health. In situations where they are involved, improvements have been seen in the utilization of services by both sexes^{10,11}. Furthermore, reproductive health programs that target couples have been shown to be more effective than those directed to individuals¹².

Male participation in reproductive health has proved to be challenging in countries where there are culturally defined gender roles and where manifestations of masculinity involve violence against women, alcohol consumption, and high-risk sexual behavior^{5,9,13,14}. In most communities in Africa, men still have a dominant role in reproductive health-related issues. A number of decisions, such as sexual initiation, contraceptive use, whether to have an abortion, prevention and treatment of sexually transmitted infections (STIs) and HIV, and sexual coercion, still depend on men¹⁵. A study conducted in a northern Ghana community revealed that introduction of family planning services brought tensions in gender relations within the community. Women were worried that their husbands and relatives would find out about their use of contraceptives, while the men believed that they alone should make decisions about their partners' contraceptive methods¹⁶.

Few studies have examined male involvement in reproductive health in Kenya. A qualitative study conducted in Kakamega (Western Province) revealed among other findings that men did not want their partners to use contraceptives for fear of extramarital sex. The same study showed that couples rarely discuss issues such as STIs and HIV for fear of accusation of marital infidelity¹⁷. Another study indicated that Kenyan men had concerns about the safety of FP methods. In FP sessions with male and female clients among certain communities in Kenya, men have been found to communicate more actively than women. Providers offered men more detailed information on family planning than they offered women¹⁸. A study conducted at Nairobi's Kenyatta hospital and Kakamega provincial hospital in western Kenya concluded that men do participate in women-centered reproductive health services to some extent. The majority of men accompany their wives to the hospital if there are fees to be paid, for obstetric/gynecological (ob/gyn) consultations, delivery, and antenatal care¹⁹. None of these studies looked at factors that influence male involvement in reproductive health and how best to go about including men in the current reproductive health services in the country.

The objectives of this study were to establish the status of male involvement in reproductive health services in western Kenya and investigate the best strategies to involve male partners in reproductive health services. The study questions addressed are "What factors influence the status of male involvement in reproductive health services in western Kenya?" and "What are some of the strategies suggested by study participants for involving men in reproductive health services in western Kenya?"

Methods

Study Design

The study was conducted using qualitative descriptive (QD) design. In-depth interviews with individual participants and focus group discussions (FGDs) were used to collect data. FGDs were conducted to complement individual interviews and to examine from a group perspective the phenomenon under study. Data were collected from December 2008 to February 2009 at three provinces of western Kenya: Nyanza, North Rift Valley, and Western.

Sampling and Recruitment

Two sampling methodologies were employed: stratified purposive and snowball sampling techniques. To get variation in responses, five health facilities were selected as focal points and were stratified by province and location (urban/rural). The study participants were stratified by gender (male/female). Health facilities were used as focal points to enable the researchers' easy access to community members for interviews. To select the focal facilities, the researchers first prepared a list of 25 facilities run by active PACNET members in the three provinces. From this list, five focal facilities were selected purposively, using such criteria as available resources, distance from Kisumu where K-MET's headquarters are based, current implementation of reproductive health services, and the willingness of the provider in charge to participate in the study. Two focal facilities were selected in Nyanza Province, two in Western Province, and one in North Rift Valley Province (Table 1).

Once the facilities were chosen, a telephone call was made to the provider in charge informing him/her of the study. The health provider was asked to be a key informant in the study and to help identify other key informants among members of the community within the facility's catchment area. If the provider agreed to be a key informant, a convenient date was set for the interview. The providers from all five facilities agreed to participate in the study.

Table 1: Number of in-depth interviews, FGDs and focal facilities per province and district

Province/District	Location (Urban/Rural)	In-depth	FGDs	#s of focal facilities per province
Nyanza Province				
Kisumu East	Urban/Slum	1	2	
Rongo	Urban	0	1	2
Rongo	Rural	2	1	
Kisii	Rural	1	1	
Sub-total		4	5	2
Western Province				
Vihiga (Chavakali)	Rural	3	1	2
Kakamega	Urban	3	1	
Sub-total		6	2	2
North Rift Province				
Trans-Nzoia (Kitale)	Rural	0	1	1
	Urban	2	0	
Sub-total		2	1	1
TOTAL		12	8	5

With the help of the interviewed providers, *snowball sampling* was used to choose key informants from the community for subsequent in-depth interviews and FGDs. The choice of the initial community member to be interviewed was based on the provider's knowledge of both the community and the individual he recommended. The providers also suggested names of other people within the community who could be interviewed, and these people provided names of others who might be willing to participate in in-depth interviews and FGDs.

Study Location

The study was conducted at six districts of the three provinces of western Kenya. The focal facilities were located in urban and rural areas and in urban slums. Table 1 shows the number of facilities and the type of interview (in-depth or FGD) conducted at each province and district.

Inclusion Criteria

- 1) Health providers from the focal health facilities, and men and women from the community willing to participate
- 2) Participants who were over 18 years of age

Exclusion Criteria

Individuals with cognitive defects who could not voluntarily consent to the interview.

Data Collection and Analysis

Interview Guide

An interview guide with open-ended questions was used to conduct in-depth interviews and FGDs. The interview guide had a section for demographic information of the participant (age, location [urban/rural], years in school, marital status, and number of children). Some examples of questions included in the interview guide were: In your opinion, how should men in your community be involved in reproductive health services/programs? What are the best approaches to include men in the reproductive health programs? What are some of the factors that can encourage men to be involved in reproductive health programs for themselves and their female partners? What are some of the factors that may prevent men from taking part in reproductive health programs?

The interview guide was in English. Kenya is a multilingual country with English as the official and the primary language of instruction in schools. Kiswahili is the national language spoken by most people. Both the principal investigator (PI) and the research assistant are bilingual. We conducted interviews in English or Kiswahili, translating simultaneously whenever necessary.

In-depth Interviews with Individual Key Informants

Twelve in-depth interviews with individual key informants were conducted, starting with the providers at the study health facilities. In-depth interviews with identified individuals from the communities were conducted either at a private

space in the clinic or a place convenient for the participant. The interview sessions lasted for 40 to 90 mins. All interviews were tape-recorded. The research assistant took notes during each interview to supplement the transcripts.

Focus Group Discussions (FGDs)

Eight FGDs were conducted, four with men and four with women. Three of the FGDs had five participants each, four had six participants each, and one had three participants. Although the optimal number of participants for FGDs is six to eight, some of the scheduled interviews had fewer than six people. In instances where participants were less than six, we held discussions with those who were present. The interview date had been scheduled about ten days in advance and those present had already taken time away from their busy schedules. It would have been inappropriate to turn them back. We had no information why some participants did not come to the FGDs. The FGD participants were not the same as those who participated in in-depth interviews.

Before starting each FGD session, the study was explained to participants individually. After confirming their acceptance to take part, the FGD process started. Selection of the location for the FGD was based on privacy, quietness, and adequate lighting. The PI and research assistant put the participants at ease and explained the purpose of the FGD, the kind of information needed, and how the information would be used. The participants were encouraged to communicate and interact with each other during the FGD. Each session lasted 45 to 120 mins. All discussions were tape-recorded, and the research assistant took notes.

In remuneration for transportation and/or food, each participant from the community was given 100 Kenyan shillings (~1.50 US\$), an amount not considered coercion in Kenya but rather a gesture of appreciation.

Data Analysis

Tape-recorded interviews were first transcribed verbatim. Before coding the data, the researchers read the typed interview transcripts and field notes line by line and word by word. Initial coding was written on the margins of scripts. The typed transcripts were imported into NVivo8, software to code and conduct content analysis²⁰. During the coding process, data were continuously reviewed and revised, emerging patterns noted, and relationships between constructs identified.

Ethics

This study was approved by the K-MET ethics committee and a Boston University Medical Centre institutional review board. Study participants were reassured that taking part in the study was voluntary. Confidentiality was maintained from data collection to report writing. The field notes and audiotapes had no identifiers that could be linked to a particular study participant. Since this study was of no more than minimal risk to participants, they did not have to sign a consent form.

Results

Demographic Characteristics of Study Participants

In-depth interviews: Five of the 12 participants were female, seven male (Table 2). Among the 12 participants, five were health providers: three female nurse midwives, one male general physician, and one male obstetrician/gynecologist. The age group of 41-50 years had the most representation with five participants, followed by the 20-30 year age group with four participants. Only one participant was in the age group of 51-60 years. Half of the participants had one to two children.

Focus group discussions: Forty-two participants took part in the eight FGDs. Among them, 27 were female, 15 male. Four FGDs were made up of males, four of females. Seven participants were less than 20 years of age. The age groups of 20-30 years and 31-40 years had 12 participants each. Four of the participants were within the age group of 51-60 years. Similar to in-depth interviews, a large majority of FGD participants had one to two children (Table 2). The FGDs were homogenous by residence and sex but varied by age, parity, and education.

The Status of Male Involvement in Reproductive Health

The findings in this section address the first study question: What factors influence the status of male involvement in reproductive health services in western Kenya? Most participants, both male and female, from all three provinces and across all cultures and age groups, were of the opinion that men in western Kenya are not sufficiently involved in reproductive health. Involving them, participants cautioned, would be a challenging undertaking. A male participant stated the importance of male involvement:

Table 2: Characteristics of study participants for In-depth Interviews and FGDs by province

Variable	In-depth Interviews (n=12)			Focus Group Discussions (n=42)		
	Nyanza (n=4) #	Western (n=6) #	Rift Valley (n=2) #	Nyanza (n=26) 5 FGDs	Western (n=11) 2 FGDs	Rift Valley (n=5) 1 FGD
Age Group (yrs)						
< 20				7	0	0
20-30	1	3	0	10	1	1
31-40	1	1	0	5	3	4
41-50	2	1	2	3	4	0
51-60	0	1	0	1	3	0
Location						
Urban	1	3	2	0	6	5
Rural	2	3	0	17	5	0
Urban Slum	1	0	0	9	0	0
Sex						
Female	2	3	0	17	5	5
Male	2	3	2	9	6	0
Years in School						
< 10				3	3	3
10-15	0	2	1	19	5	2
16-20	3	4	1	4	3	0
21-25	1	0	0	0	0	0
Marital Status						
Married	4	4	2	11	5	5
Single	0	2	0	15	6	0
# of Children						
1-2	2	3	1	20	5	0
3-5	2	0	1	3	5	4
6-8	0	3	0	3	1	1

In reproductive health you want the mother to be safe and the baby to be safe and if the man is not involved the mother will not be safe and the baby will not be safe. (Male participant, in-depth interview, Nyanza Province)

The two main themes that emerged as factors influencing the status of male involvement in reproductive health in western Kenya were 1) gender norms and 2) the traditional approaches used to implement reproductive health and family planning programs in the country.

Gender Norms

This study revealed that the existing gender norms among cultures in western Kenya influence and determine the extent of male involvement in reproductive health. Four factors were mentioned by participants to illustrate how men exhibit these norms: negative cultural practices, parenting practices in relation to reproductive health, prevention and treatment of sexually transmitted infections (STIs), and accompanying/not

accompanying female partners to the health facilities.

Negative Cultural Practices

Participants pointed out that certain cultural practices in western Kenya impact male involvement in reproductive health. These include polygamy, naming of newborn children after relatives, preference of children of a certain sex over the other, and socialization of male children.

Participants asserted that some of these practices are deeply rooted in culture and will take time to change. An example was given of men who come from families where polygamy has been practiced for generations. These men have no incentive to practice family planning because of pressures within their culture which dictate that a man should have many children. A woman who is in a polygamous marriage and wishes to stop giving birth most often has to take her own initiative.

The common traditional practice in parts of western Kenya that close relatives from both sides (e.g., mother in-law) want children to be named after certain relatives (dead or alive) was also mentioned as a factor. This demand puts pressure on women to

deliver many children and makes men more reluctant to be actively involved in family planning activities with their wives. One participant explained:

You find if the mother-in-law comes she encourages the man and he says he has not given birth to the grandmother, aunt, and so on ...you find if her daughter-in-law has given birth, she comes with a name. When asked who the name belongs to, you are told it was her father's brother...so there's no way out. (female participant, FGD, Western Province)

A participant in a female FGD gave an example of how some men's preference for children of a certain sex (male or female) is driven by culture and affects their involvement in reproductive health issues, especially family planning.

They'll say that, see she's only given birth to girls. He forces you to give birth endlessly until you get a boy...you may reach 10 children....they'll again complain, 'why haven't you given birth to a girl?' So you find women giving birth to many children. (female participant, FGD, Nyanza Province)

To further illustrate the depth of negative cultural practices and how they affect male involvement in reproductive health, one participant gave an example of how in most African societies boys are socialized from an early age not to be involved in reproductive health issues. For example, teenage boys are never held responsible for impregnating girls, but when a teenage girl gets pregnant, her mother is considered a failure for not having performed her duties of proper upbringing.

If a boy impregnates that is a good sign that you are a performer...It is only when the girl gets pregnant that is especially unacceptable... If the boy impregnates a girl it is normal... nobody bothers, it is like the father has not failed, the father will be very happy my boy is ok. (health provider, in-depth interview, Western Province)

Parenting Practices in Relation to Reproductive Health

In western Kenya, as in many parts of the country, childbirth and child rearing are traditionally women's responsibilities. In his role as the head of the household, the man in the family is not expected to discuss matters of sexuality with his female children. This cultural belief not only protects men from

discussing issues of reproductive health; it contributes to the general lack of male involvement in reproductive health. Although the majority of participants mentioned that most married men (especially the older generation) rarely discuss reproductive health issues with their wives and children, the younger generation is considered more open and can talk more freely about reproductive health.

Prevention of STIs

A majority of participants lamented that the men do not fulfill their responsibility of informing their partners when they are experiencing a reproductive health-related illness. Men who contract an STI usually seek treatment secretly without informing their wives. To most participants, a man's traditional role as head of household can lead to a lack of communication on crucial health issues like STIs and, more generally, a lack of involvement in reproductive health.

Female participants reported that most men avoid attending clinics where they are likely to undergo medical tests. They prefer to access reproductive health services by proxy. Only a serious illness is said to force men to attend a clinic. A comment from a female FGD participant supports this statement:

Culturally, men don't like discussing issues surrounding reproduction with their wives. They'd rather discuss them outside with other people. (female participant, in-depth interview, Nyanza Province)

STIs and HIV/AIDS are highly stigmatized among communities in western Kenya. Infection with an STI is viewed as a gauge of immorality. The infected are perceived to be of loose morals.

If you get an STI you are immoral. That's how the community looks at you, especially gonorrhoea; it is a disease of the harlots....so many of them still have that understanding and I think it hasn't been removed yet. (female participant, in-depth interview, Western Province)

When women seek treatment for STIs, they do not like to involve men. Most women who go for STI treatment blame their men for the infection, but since men rarely admit to being the source of an STI, the women do not bother involving them. As one female participant stated:

Even if you got it from them they would not agree so there is no need going with him for check upin any case, if you involve him it

would bring more quarrels, and disagreements. (female participant, FGD, Western Province)

Accompanying Female Partners to the Health Facilities

Men in western Kenya rarely accompany their partners to the RH clinics, a fact attributed to gender norms, low awareness, and lack of male reproductive health education programs. As a result, many men do not think it is important to participate in reproductive health issues. Typical excuses they give are that they're busy or that reproductive health is a woman's responsibility. Since men do not commonly seek family planning or other reproductive health services, they see no reason for going to the clinics.

I think your teaching should be seriously and basically on the ABCs of reproductive health because majority of us do not know about it. (male participant, in-depth interview, Nyanza Province)

Participants reported that men do not want to accompany their wives to the clinics because they associate the reproductive health facilities with family planning and contraception. This belief affects their involvement in reproductive health because to most men in western Kenya, contraception means only vasectomy, a procedure they are not enthusiastic about because they believe it interferes with sexual performance.

The opinion of peers also has an impact on male involvement. A man who usually accompanies the wife to the clinic is branded as being overpowered by her. Remarks from peers such as, "This one drops the wife to the clinic" or "He goes to the women's clinic" are viewed as insulting and keep the men away from reproductive health clinics. Men loathe being branded as *amekaliwa* (Kiswahili for being henpecked) by their female partners. Two comments from FGD participants illustrate this notion:

It is culture, if my friend (Mr. X)...sees me take my wife to the clinic he will say huyu amekaliwa (this one is henpecked), but if we are taught together he wouldn't burst me...but right now if I also see him take his wife I will tell him bwana umekaliwa na bibi nyumbani (Mister your wife controls you at home). (male participant, FGD, Nyanza Province)

You know according to culture, men are taken as kings, so if you're seen carrying a baby, you are seen to be 'voiceless'. Also, if

you are so much concerned with women, they'll see you to be voiceless. (male participant, FGD, Nyanza Province)

Thus, for most men, involvement in maternal and child health and reproductive health issues implies a weakness—they won't be seen as total men. Men also fear that accompanying their female partners to the reproductive health facility would increase their vulnerabilities and expose any reproductive health secrets, exposures that could reduce their social status.

Despite the challenges brought about by the prevailing gender norms in western Kenya, both male and female participants agreed that there are benefits for men to be more responsive in matters concerning their own reproductive health and that of their partner. Among these benefits are an increased understanding of pregnancy and related issues, and enhanced levels of preparedness, from the time the female partner is pregnant until she delivers.

Traditional Approaches to Reproductive Health Programs

Both men and women lamented the fact that the way family planning and reproductive health services are traditionally implemented by the health care systems contributes not only to a lack of male involvement in reproductive health but also to most men's limited knowledge of reproductive health issues.

Male Support for Reproductive Health and Family Planning

Participants pointed out that the majority of men in western Kenya do not understand their family planning responsibilities. Because these responsibilities have traditionally been left for women, men do not know the possible consequences or side effects of specific family planning methods. Their lack of knowledge was attributed mainly to the fact that family planning was introduced to communities by the health systems as a service for women and children.

In the few instances when men accompany their partners to the clinics, the health providers don't allow them inside the consultation rooms with the partner. Consequently, the society has come to think that any reproductive health issue belongs to the domain of women and should not readily be embraced by men. One participant stated:

When family planning came, they started talking to the women and left the men out,

*so the men knew it was a woman's affair.
(male participant, FGD, Rift Valley Province)*

Male participants in focus groups narrated some myths attributed to family planning methods, which further illustrate their limited knowledge on these issues. One suggests that family planning drugs make the woman cold in bed. Others relate that family planning increases women's complaints about backaches, chest problems, stomachaches, and inability to perform heavy duties.

Suggested Strategies for Involving Men in RH in Western Kenya

The findings presented in this section address the second research question: What are some of the strategies suggested by participants for involving men in reproductive health services in western Kenya? Four main themes emerged: creating awareness, male friendly clinics, advocacy and policy on male RH, and women empowerment (Table 3).

Creating Awareness

A majority of the study participants were of the opinion that creating awareness and sensitizing the men were the most important interventions. Seminars were proposed as the most effective way to conduct male reproductive health education. Participants gave a number of reasons: Seminars promote a sense of commonality and provide a venue where men can meet other men with the same interests, problems, and concerns regarding RH; gain knowledge by listening to experts; and strengthen their motivation to participate in male RH

programs. Even those who never attend RH clinics will benefit from the seminars. A majority suggested that men and women should be separated during the seminars to enhance the flow of information:

*But if we are only women even if my mother in law is there I am free but if you mix them with men and maybe a man has a question or is sick and wants to inquire about it he fears... so it is good they be separate.
(female participant, in-depth interview, Nyanza Province)*

Other suggestions for creating awareness involved the use of mass media and mobile phone technology. Various forms of edutainment activities, such as sporting events, family fun days and popular Kenyan musicians, were also mentioned. Approaches that can be used at the community level include community outreach using men-to-men for reproductive health teaching. Men could meet at the chiefs' camps, male clubs, bars, and traditional male games common in western Kenya. Village markets were also suggested as ideal catchment areas for men. The value of informal talk was brought up by some participants who said if you treat a man for an STI, he is likely to refer his male friends to the facility where he received treatment.

*Men are good at spreading the word to other men, with the same problem they had undergone.
(male participant, in-depth interview, Rift Valley Province)*

Participants in all three provinces highlighted the need to prioritize youth participation in any male RH involvement intervention and especially awareness creation. The *jua kali* (informal sector) provides

Table 3: Summary of Suggested Strategies for Male Involvement in RH

Creating awareness	Male friendly clinics	Advocacy & policy on male RH change	Women's empowerment
<ul style="list-style-type: none"> • Seminars • Media • Mass, print & mobile technology • Community forums <ul style="list-style-type: none"> ○ Chief's baraza ○ Village markets ○ Community resource centers ○ Men only community groups ○ Traditional male games ○ Community outreach ○ *Men-to-men strategy • Targeting the youth • Targeting schools • Edutainment <ul style="list-style-type: none"> ○ Family fun days ○ Sports ○ Popular musicians 	<ul style="list-style-type: none"> • Train providers • Provide privacy & confidentiality • Address male RH needs • Link clinics with community based initiatives <ul style="list-style-type: none"> ○ Invite male role models • Provide incentives to male clients 	<ul style="list-style-type: none"> • Male RH policy • Husband to attend the clinics with spouses • A law for male participation to be instituted • Employers to allow men clinic time 	<ul style="list-style-type: none"> • Economic empowerment for women

employment to a significant proportion of the youth. Some of them are in the bicycle and motor bike transportation business, known locally as *boda boda*. Involving the youth would require designing creative mobilization activities such as road shows with reproductive health messages. The road show should include drama, which has the capacity to attract many people and reach the out-of-school youth.

Male-Friendly Clinics

A majority of study participants suggested that providing a separate section for men in the health facility, offering privacy and having men attend to men would encourage their participation and make the clinics more male-friendly. Since men do not like being kept waiting for long periods of time, prompt services would make a facility male-friendly. Men are also very particular about privacy and confidentiality, and these needs must be recognized when establishing male RH services at the clinic and community level.

Offering male RH services on special days was mentioned as an option that could attract larger numbers of men. On these days, the facilities could offer such services as free consultations; selected diagnostic tests; prostate-specific antigen estimation, blood pressure, and diabetes screening; and counseling services on issues related to male sexual performance and infertility. Training of health providers was also strongly suggested. The trained providers would be able to link the clinic activities with the community-based initiatives.

Advocacy and Policy on Male Reproductive Health

A majority of participants stated that the government should have a male RH policy. The policy should state among other things that anytime a woman is pregnant she should be told that the husband must attend the clinic. Perhaps a law could be instituted that would compel men to accompany their female partners to the clinic—especially when pregnant. The policy or law should also state the need for employers to provide antenatal clinic time for men. The government should take the initiative to teach the men that RH is not just about women and children.

If a woman is pregnant she should be told to go back home and bring the husband in case she's alone, something like a by-law, the one who has given you the pregnancy...we can't treat you without your wife...do you have a wife? Go bring her with you. (male participant, FGD, Nyanza Province)

Empowering Women

Some participants mentioned that widespread poverty among women increased their vulnerability and dependency on men. Economic empowerment was suggested as a strategy that could give women a voice and enhance their partnerships with men in reproductive health. Women's empowerment is thus seen as an approach that will make them more assertive in RH decision making.

If I were a Mdosu (rich man) today I would have a den of serviceable ladies because all that they will be interested in is the thing that will help them run their daily living. So we need to come up with projects that can uplift livelihoods of the women especially in the Luo Nyanza. (male participant, FGD, Nyanza Province)

Discussion

The findings in this study indicate that the prevailing cultural norms in the western Kenya region determine gender norms and the subsequent male involvement in reproductive health issues. Additionally, the traditional ways in which reproductive health programs are implemented play an important role in influencing not only the involvement of men but also their knowledge and appreciation of reproductive health issues. Although these findings are similar to those of other studies, which have found that certain gender norms can affect male involvement in reproductive health issues⁶, they are important for RH programming in western Kenya.

The gender norms mentioned by participants in this study, such as polygamy and preference of children of a certain sex, are so deeply rooted that they need to be given serious consideration in the design of reproductive programs in the region. These culturally sanctioned practices have created an environment where a majority of men are not expected to be actively involved in reproductive health matters in the first place. Men in these communities neither understand women's reproductive health nor participate adequately in their own reproductive health issues.

Providers seeking to promote sexual and reproductive health for men in western Kenya should be sensitive to the fact that if men are not taking full responsibility for their sexual and reproductive behavior, the reason may be that they are acting within a set of cultural norms that determine gender relations. For reproductive health programs to benefit both men and women, they should be based on a better understanding of gender dynamics in the region. Reproductive health

work here requires great sensitivity to social and cultural factors that may not appear closely related to health. Interventions to involve men should thoughtfully take gender relations into account to find ways of enhancing women's status and involving men in supportive partnerships and their own reproductive health.

The focus group discussions helped identify important gender and other cultural norms around male involvement. At the same time, the in-depth interviews allowed investigators a fuller understanding of partnership dynamics and of how men and women individually interpreted these norms.

As regards interventions, we recommend that interveners use a framework which includes strategies for community entry involving influential community leaders. Health providers in the region should be trained on male reproductive health. The training will facilitate the integration of male sexual and reproductive health into the existing programs making the clinics male-friendly.

Strategies to create awareness on male SRH issues should be given priority at the clinical and community levels, with the aim of establishing a large number of adopters of male involvement in reproductive health. Approaches may include seminars and media (mass media, print and mobile phones). Men will be found at the community forums like chief's *barazas*, churches, and village markets, and at the traditional male games. The youth are an important group that should not be overlooked. While these strategies are being implemented, interveners and other partners need to start discussions with relevant ministry of health departments for an explicit policy on male sexual and reproductive health in the country.

Researchers need to plan and conduct scientifically designed intervention studies at various pre-planned periods during the life of such projects. Such studies will facilitate periodic evaluations and reviews of the implementation plans and progress. They will also provide evidence-based data and practices that can be shared with other stakeholders, including ministries of health, partners, and donors.

Conclusion

Culturally sanctioned gender norms and the traditional ways of implementing RH programs appear to influence male involvement in reproductive health in western Kenya. Finding ways to address these gender norms within reproductive health programs is fundamental. A review of traditional attitudes is necessary in order to

implement sexual and reproductive health services that are male-friendly.

Study Limitations

This study had a few limitations that the researchers would like to mention: Due to the nature of qualitative study designs, the findings from this study are not generalizable to all of western Kenya. However, data collection methods (in-depth interviews and FGDs) have provided rich data and sufficient insight on the issue. This study will facilitate discussions and initiation of male involvement in sexual and reproductive health programs in western Kenya.

During data collection, the available resources and time limitation did not enable the researchers to conduct interviews in more districts within the three provinces in western Kenya. This limited coverage did not provide for a wider representation from some cultures. Nevertheless, there was no indication from the findings that the cultural norms regarding sexual and reproductive health issues differ significantly within western Kenya.

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