

DRAFT REPORT

**Effective Delivery of Reproductive
Health Services to Men:
A Review Study in Kenya and Malaŵi.**

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1. Introduction

The importance of men as partners in achieving good reproductive health has been well documented over recent years. Male involvement in family planning and sexual health has been recognised as an important component in reducing fertility levels in developing countries and improving the sexual health of men and couples.

Fertility and family planning surveys amongst men in 15 countries in Africa and Asia (Ezeh *et al* 1996) provide strong evidence to contradict popularly held views that men have low levels of knowledge about family planning, do not approve of contraceptive use and prefer larger families than women. In seven of the fifteen countries at least 90 percent of men approved of using contraception. In all but one African country (Rwanda) a greater proportion of men had knowledge of a modern method of contraception than women. In most of the study countries there was little difference between men and women in the desired family size. Demographic and Health Survey (DHS) data also show that the majority of men have heard of HIV/AIDS, most are aware that it can be sexually transmitted and that condom use is one means of protection from infection (Robey and Drennan 1998). The study by Ezeh *et al* (1996) also reveals the existence of a “KAP Gap” among men, whereby there exists a contradiction between the high level of knowledge and positive attitudes about family planning compared with actual contraceptive practice. Given high levels of knowledge and approval for family planning men’s contraceptive use is shown to be lower than might be expected. One of the implications this finding is that if family planning programmes could find better ways to reach men and couples contraceptive use might rise considerably (Robey and Drennan 1998).

With the growing interest in men’s participation in reproductive health, more attention is being paid to learning how to reach men effectively through reproductive health programmes. This has been reflected in the range of initiatives to deliver reproductive health services to men, which have emerged during the last 5-10 years. These initiatives include the provision of reproductive health information and/or services to men through workplace schemes, outreach services, men’s discussion groups and specialist services. Such services have been delivered through both outreach and static services.

While reproductive health services for men exist, little work has been conducted to date to evaluate the effectiveness of various delivery strategies, or to assess the most appropriate and cost effective modes of service delivery to men. Service effectiveness may be measured from both the users and providers perspectives. In terms of the user’s perspectives, effectiveness may be measured by the acceptance or preferences of males for different types of reproductive health services. From the providers’ perspective, service delivery criteria, such as cost, staffing, or outcomes of different approaches (such as increased knowledge and use of services) can be used as measures of effectiveness. The evaluation of service delivery to men has strong policy implications. Increasing knowledge amongst service providers on effective modes of reproductive health service delivery for men will enable providers to deliver services in forms which are most acceptable to male clients. In addition, an evaluation of services may identify gaps in the current delivery of services to men, allowing providers to target service provision to the current needs of clients.

This report provides an overview of the issues involved in providing sexual and reproductive health services to men. It reviews the current range of services and initiatives for men in both Malawi and Kenya, which is then to be used as baseline information in developing an evaluation study in these two countries. An evaluation of reproductive health services for men in two countries has the potential to examine effective modes of service delivery and highlight differences between countries. This process may identify cultural influences on the delivery of reproductive health services to men, which may have implications for transferring service delivery protocols across cultural divides.

2. The Shift in Focus Towards Male Involvement in Reproductive Health.

Family planning has traditionally been perceived as the domain of women, particularly since the introduction of “female-oriented” modern methods of contraception, such as the oral pill, IUD and injectable methods. Consequently the design and delivery of family planning services and family planning research during the past 30 years has largely focussed on women. This is reflected in the provision of family planning services, which have typically been provided through maternal and child health centres, and (until the mid 1980s) the focus of large-scale family planning surveys on women only. However, more recently, the focus of family planning programmes has become more inclusive of men (Temmerman 1998; Edwards 1994). This shift in focus may be attributed to a range of influences, including; socio-cultural factors; the rise of HIV/AIDS; a change in focus of research priorities and the increase in information about men’s knowledge and approval of family planning to dispel beliefs of their lack of interest in family planning. The inclusion of men in reproductive health provision has a both a direct benefit of improving the reproductive and sexual health of men themselves, and also the indirect benefit of improving that of women.

One of the reasons for involving men in reproductive health is the resulting benefit this may have for women. In male-dominated cultures where men are community, religious, professional and political leaders, they are instrumental in promoting or hindering family planning both at the policy level and at the individual level (Hulton and Falkingham 1996; Edwards 1994; Davies *et al* 1987). In such an environment, even when women are educated and motivated to practice contraception they may have little control over family planning decisions if the husband is opposed to contraception. For example, in Sudan, family planning decisions are male-dominated and when contraception is used it is the husband who supplies that method (Bankole and Singh 1998; Khalifa 1988). In this situation it is the men who come into direct contact with family planning service providers. Therefore, it is crucial to provide men with information and education about family planning and to include them in the reproductive health equation. In these situations “the inclusion of men may act to neutralise resistance, passive or active which they pose to women in this regard” (Hulton and Falkingham 1996: 91).

“The failure to include men in reproductive health programmes leaves them less informed or misinformed about contraception, feeling incompetent or inhibited to discuss it with partners” (Hulton and Falkingham 1996: 91). Studies show that when men are provided with information about reproductive health they are more likely to

be increasingly supportive of their partner's family planning decisions, and that contraceptive use is dramatically higher among couples who have discussed family planning with each other (Ndong *et al* 1999; UNFPA 1995; Temmerman 1998; Hulton and Falkingham 1996). It is therefore beneficial to include men in reproductive health programmes to curb false information regarding contraceptive use or its effects on men or women and to encourage spousal communication about contraception.

The inclusion of men in contraception and family planning programmes has now become increasingly urgent with the spread of the HIV/AIDS, to ensure the sexual health of men themselves and their partners. None of the female controlled methods of family planning is thought to offer any protection against HIV infection, so the re-emergence of condom use has necessitated the involvement of men in sexual and reproductive health programmes (Edwards 1994). The introduction of STIs, particularly HIV, into the framework of reproductive health care provision has led to men becoming central to intervention strategies and reproductive health programmes. One of the key differences between HIV/AIDS prevention programmes and family planning programmes is their approach to gender issues. While most family planning programmes have marginalised men, in HIV/AIDS programmes men have become a central focus (Green 1997). The increasing need for STI/RTI control programmes now provides "a biomedical rationale for researchers and programme managers to target men in addition to the social and cultural reasons" (Collumbien and Hawkes 2000: 137). In addition, effective STI treatment programmes require communication between sexual partners, as both partners need to be provided with education, testing and treatment (Ndong *et al* 1999; Wegner *et al* 1998).

The 1994 International Conference on Population and Development (ICPD), in Cairo, highlighted the need to refocus attention towards the inclusion of men in reproductive health programmes. It highlighted for policy makers, programme planners, researchers and health advocates that the sexual behaviour and reproductive health of men has a direct effect on women's health. The widening of the field of "family planning" to "reproductive health", has also led to the inclusion of STI prevention strategies in service delivery programmes. This requires service personnel and researchers to consider the needs of both men and women (Bankole and Singh 1998). The ICPD Programme of Action specifically states that "special research should be undertaken on factors inhibiting male participation in order to enhance male involvement and responsibility in family planning" (United Nations 1995: 64) and identified the need to develop innovative programmes that reach men with reproductive health information and services, with the main goal of promoting greater gender equality. The conference also drew attention to gender issues, indicating that if men were not included in the reproductive health equation they are unlikely to exercise responsibility (Robey and Drennan 1998). The key areas for action were; to promote the use of male methods of contraception, encourage men to support their partner's use of contraception through joint decision making and adopting responsible sexual behaviour to prevent the spread of STIs (Collumbien and Hawkes 2000). Both the ICPD and 1995 Fourth World Conference on Women, held in Beijing, provided a foundation for expanding family planning services to include men. The ICPD established a clear foundation for family planning policy development and programme delivery, from which to build improved men's participation in reproductive health, and the conference in Beijing reiterated the central role of men in

contributing to women's access to reproductive health care and information. There is increasing awareness that the inclusion of men in family planning programmes will not only act as a means to improving women's reproductive health but also their own sexual and reproductive health needs.

3. Issues in Reproductive Health Service Provision for Men

Reproductive health service providers have been able to access women through the existing infrastructure of maternal/child health facilities and family planning clinics, however, there no parallel services exist through which to access men. Many men are reluctant to seek reproductive and sexual health care and generally do not access such services; healthcare programmes therefore cannot use the same strategy to access men as they do for women. Men therefore have fewer opportunities than women for receiving family planning information, counselling and services. Programmes that have relied on reaching men through the same channels as women and have relied on women outreach workers have typically had difficulty in reaching men (UNFPA 1995; Wegner *et al* 1998). Strategies successful in reaching men have often involved bringing reproductive health services to places where men congregate, such as workplaces, or men's social organisations. Where programmes have reached men, male attitudes have changed and contraceptive use has increased (UNFPA 1995). Providing sexual and reproductive health information and services to men is not straightforward, therefore service providers face a range of unique issues which impact on the effective delivery of reproductive health services to men, some of which are outlined below.

a) Clinic Delivery Barriers

As family planning delivery and clinic environments were largely designed for use by women, it is unsurprising that the services delivery point itself can act as a barrier to men's utilisation of these services. Family planning services have typically been provided through speciality areas of hospitals (ie: obstetrics and gynaecology) or specialist community services (ie: family planning clinics, maternal and child health clinics). There exists no comparable arena of reproductive service delivery for men. Reproductive health services for men are typically housed in settings where the environment itself, the décor, posters, literature and brochures may not reflect men's interests or needs (Ndong *et al* 1999). More recently, however, male family planning clinics are being established (eg: Kenya, Uganda, Ghana, Pakistan, Columbia). These clinics may be in a separate building, or they may be housed in the same facility as the family planning clinic used by women but have specific adaptations. For example, the male clinics in Bogota, Columbia, provides a separate entrance, waiting room and cashier for men and has male clinic staff (AVSC 1997).

There is a strong belief that the attitudes and biases held by policymakers, programme managers, health care workers and other types of providers can act as barriers to men's utilisation of reproductive health services (Green 1997; UNFPA 1995). These barriers may exist because of the social or cultural values of providers, the belief that men are not interested in reproductive health issues, or simply the assumption that family planning is a woman's responsibility (Wegner *et al* 1998). Both structural and

attitudinal issues may act as significant barriers within family planning clinics to limit service provider's ability to provide services to men, and inhibit men's use of services. Improvements in reproductive health delivery to men must involve training of services providers to supply them with the information they need to provide quality care to male clients, to assess to their own attitudes and biases about methods and clients and how to create a service environment that is welcoming for male clients (Wegner *et al* 1998).

There has also been a growing understanding in the international public health community that the role of gender has a fundamental influence on health care delivery (Wegner *et al* 1998). Providers of reproductive health services need to understand how cultural constraints related to gender can affect service delivery; for example, culturally and socially appropriate language facilitates the discussion of sensitive issues like sexuality (Ndong *et al* 1998). Understanding the role of gender in service delivery has been instrumental in making reproductive health professionals aware of the need to develop gender sensitive strategies.

b) Integrated vs Separate Services

A further issue in the provision of reproductive health services for men is whether to house services in the same facility as women or provide separate facilities. Although housing services for both men and women in the same facility is the most cost effective use of resources, trying to encourage men to utilise services which have traditionally been used by women, and asking men to use these alongside women may present significant cultural, social and practical barriers (Wegner *et al* 1998). In addition, integrating services for both men and women may cause reluctance amongst women to use services where men are likely to be present. Providing separate services for men may be particularly appropriate in societies where the sexes are often segregated. In Pakistan, for example, one family planning organisation now houses men's and women's services in the same facility, but separated by different floors and hours of operation. In Columbia, ProFamilia's experience of designing a separate male-only vasectomy clinic showed that although a higher number of vasectomies were performed, men's satisfaction with services did not increase (*ibid*). Therefore from a quality perspective, whether services are provided in different locations may not be the critical issue.

Some providers of reproductive health services and advocates for women's health believe that creating specific services for men will create additional competition for already scarce resources and will compromise the quality and operation of services provided for women (UNFPA 1995; Green 1997) Although the start up cost for such services may indeed be prohibitive in some settings, it is becoming increasingly apparent that adding men's programmes can enhance rather than deplete existing programmes and also has a positive impact on the reproductive outcomes of women (Ndong *et al* 1998; Wegner *et al* 1998). Integrating services for men into a country's existing health care structure is the key to achieving sustainability and to ensuring that programmes for men do not compromise existing programmes for women. The critical issues in programme sustainability are institutional capacity (staff training and commitment) to provide for the sexual and reproductive needs of men and cost issues.

c) Mobile Services and Outreach Strategies

Men often do not seek preventative health care or information in the same way as women and have so have little contact with reproductive health services. For these reasons some service providers have focussed on mobile services and outreach strategies to deliver sexual and reproductive health services to men. In communicating with men, experience of programmes shows the value of reaching out to men in the places where they gather and feel comfortable and thus are more receptive to new information. Programmes can also reach a greater number of men when they go where men naturally congregate and form a ready audience, such as workplaces, social clubs, or sporting events. The success of many contraceptive social marketing programs over the years is testimony to the validity of this direct approach. Mobile services are another strategy to take the service to potential male clients. Mobile services have not only become an important mode of delivery in rural areas, where access to services may be poor, but also for urban neighbourhoods and for serving “at risk” communities such as sex workers, drug users or slum neighbourhoods (Wegner *et al* 1998). Often mobile services are “attached” to an existing clinic to which clients are referred for supplies or services.

Providing reproductive health information and services to men at their place of employment has become an increasingly popular mode of delivery. The main argument favouring employment-based programmes is that they enable access to large numbers of men. Through workplace schemes men are provided with information, contraceptives and referral to static services. These programmes are especially suitable for promoting condoms, as they are a non-medical method and workers can easily be trained as educators to promote their use. Large employers such as plantation owners, industrial and commercial enterprises have participated in workplace schemes. For example, workplace motivators in Kenya are employed at local factories to teach fellow employees at lunch times and at after work seminars about contraception, birth spacing, and HIV/AIDS. They sell contraceptives, (pill and condom) to men after work, and encourage couples to make reproductive decisions together. They also refer clients to the Family Planning Association of Kenya’s (FPAK) clinics for vasectomy or tubal ligation. The FPAK also puts on puppet shows in the local park at lunchtimes, to educate both men and women about contraceptive methods, STI/HIV prevention, and available services. At the end of each show the puppeteers invite questions from the audience (Drennan 1998). Increasingly, workplace schemes have targeted more traditional male employment sectors and civil sectors. For example, information on STI is incorporated into basic military training in Cameroon; Marie Stopes Kenya provides reproductive health information for the curriculum of the National Youth Service, and PATH had a project to offer STI self-assessment to dock workers in the Philippines (Wegner *et al* 1998).

Aside from the benefits of workplace schemes for reaching men, workplace schemes also foster good relations between the healthcare system and private sector, shifting importance to preventative healthcare. The commitment and support of management are essential for the success of such programmes. For optimal worker participation the workplace sessions must be structured so employees are not indirectly penalised for attending the sessions (by missing a break or an important meeting). Programmes need to be flexible in arranging short programmes which are scheduled during

suitable breaks or at weekends, to overcome the reluctance of managers to release workers during shift time. The way these schemes are marketed as well as the assurances of confidentiality is pivotal to their success (Wegner *et al* 1998). While the management may be understandably concerned about cost of these schemes, the better health of the workforce may have economic benefits in the long term. The labour costs for some businesses in Kenya are estimated to rise by 16 percent by the year 2005 due to HIV/AIDS (Green 1997). Shell Brazil estimated that it spends an average of US\$11,000 for each HIV infected worker, however the loss of workers in their peak productive years is also costly to employers (*ibid*).

A further outreach strategy has been initiated by the Planned Parenthood Association of Ghana (PPAG), which observed that in the palm plantations in western Ghana workers gathered to chat, drink or play games in their leisure time. The fieldworkers organised these men into a *Daddies Clubs* and provided them with indoor recreational games as an entry point for discussion on family planning and other reproductive health topics. In 1980 PPAG pioneered the *Male Involvement in Family Planning* project, which further developed these men's discussion groups amongst taxi drivers unions, garage associations, young men's clubs, industrial and agricultural institutions, artisans groups, vocational training institutes. By 1997 the project covered 7 of the country's 10 regions. The main IEC materials used in the programme included; group discussion, lectures, debates, symposia and films. Condom wearing competitions, model penises are regularly used to impart knowledge and skills on condom use. Satisfied clients are used to promote vasectomy, and to discuss in-depth the benefits, side effects, and fears associated with family planning methods. PPAG also supported recreational activities, whereby they generate discussion on reproductive health issues, sometimes arranging excursions whereby men could receive information on reproductive health while socialising with other men. Volunteers from the *Daddies Clubs* are also trained as community based distribution (CBD) agents to counsel, provide contraceptive services and make referrals to health centres where necessary (Ndong *et al* 1998). At the beginning of each year PPAG field officers meet with club members to discuss a programme of activities. This inclusion of members in the programme design has generated a sense of ownership and empowerment amongst members.

Outreach services to sporting events has also been a popular method to reach men with family planning information. One notable example is the *Challenge CUP* initiative, which was launched in 1997 in Ghana, Uganda, Zambia and Kenya; CUP stands for "Caring, Understanding Partners". The *Challenge CUP* was a football competition at which a range of materials with key reproductive health messages were distributed to the large crowds attending the games, these included trading cards of football stars, T-shirts, sun visors, bumper stickers, and informative pamphlets. In conjunction with the games, coaches and football players were counselled about positive reproductive health behaviour. The football matches brought thousands of men together often with their wives and children to watch the teams compete and at the same time learn about reproductive healthcare. A number of star players also served as spokesmen and role models, speaking about spousal communication and STI prevention at half time during matches and also on radio and television (Robey and Drennan 1998). Similar strategies have been conducted in Zimbabwe, using slogans such as; *Play the Game Right* and *The Dream Team* as metaphors for family planning promotion activities at sporting events (Johns Hopkins 1997).

A further initiative in southern India involved more than 250,000 barbers who were trained as community health advocates to discuss family planning and distribute condoms to clients. Village men reported that they feel more comfortable talking with barbers than to clinic workers about contraception (Associated Press 1997). In Nigeria, HIV/AIDS educators have used the legendary traffic jams in Lagos to educate stalled commuters about HIV/AIDS. The project first surveyed commuters in three sites, to develop appropriate messages, and now distributes free condoms, stickers and pamphlets to commuters and pedestrians (USAID 1995).

d) Information

Men are often not aware of their own reproductive health needs or those of their partners. They may not have sought reproductive health care, believing it to be a woman's domain, and have fewer opportunities than women for receiving counselling and information from service providers. It is therefore crucial to develop a variety of information and communication strategies that are appropriate for men and increase their knowledge and access to services. However, special care is needed in designing information, education and communication messages for men, as messages developed for women or adolescents may not work for men. It is crucial to learn from men what services they want, what information men need and to use this information to design communication approaches which are acceptable and appropriate (Robey and Drennan 1998; Wegner *et al* 1998). Messages also need to be gender sensitive and programme managers need to be careful not to reinforce gender stereotypes. For example, in Jamaica, a new condom called *Slam* was designed particularly to appeal to young men. Although the condom was named after the title of a popular song about a dance hall queen, critics of the campaign were concerned about the violent implications of the condom's name, and felt that it demeaned women and may encourage men to treat them badly (Drennan 1998). The key to increasing men's participation is to develop messages that are relevant to their own concerns, which may not correspond to messages that policy makers feel men should hear. For example, in Columbia, a communication strategy to promote the awareness and use of condoms, amongst young men aged 15-25, originally focussed on condom use for birth spacing and maternal health. During pilot testing it was found that these issues were not of primary importance to young men and they found them to be irrelevant. Young men reported that they were primarily interested in having a good time on weekends and that the threat of HIV/AIDS may constrain their freedom and lifestyle. To reach young men more effectively the campaign slogan was modified to; "Keep Being Free: Use Tahiti Condoms", which promoted condoms for reasons which young men felt were important (Johns Hopkins 1997). Condom sales increased by 74% after this campaign (*ibid*).

Successful IEC campaigns can lead to increases in contraceptive use amongst men. In Zimbabwe, the *Male Motivation Project* was the first family planning IEC campaign for men in sub-Saharan Africa. It was launched in 1988-89 and involved a multi-media communication campaign to promote family planning amongst men. It consisted of a 52 episode radio drama, *Akarumwa Nehekuchera* ("You reap what you sow"), 60 motivational talks for men held in mines, farms, factories and villages and two pamphlets about family planning and contraceptive methods. The primary

objectives of the project were; to increase knowledge of family planning methods and promote more favourable attitudes towards family planning amongst men, to increase the use of modern methods amongst couples and to encourage couple communication about contraception and family size. Overall the project showed that a multimedia campaign can influence male awareness, attitudes towards decision-making and family planning practice. For example, the use of a modern method of contraception was higher amongst men exposed to the campaign than men who were not (62% and 51% respectively), condom use was higher amongst men exposed to the campaign (42%) than those who were not exposed (30%), awareness of family planning was also higher amongst those men exposed to the campaign, primarily due to their greater awareness of condoms. (Piotrow *et al* 1992). During the campaign men's use of family planning methods increased from 56% to 59% over the 16-month interval, which is equivalent to an annual increase of 2.7%. Condom use also increased from 6% to 10% (*ibid*).

Also in Zimbabwe, the 1993-4 multi-media campaign, "Family Planning: it's your Choice" promoted men's use of family planning with the co-operation of prominent male sports players, who told men of the importance of practising family planning. However, an unintended outcome of the campaign was that men felt it was their decision *alone* which was important in whether to practice family planning (Johns Hopkins 1997).

e) Community Participation and Ownership

Involving the community in the design and delivery of services is another important component to programme uptake and acceptance (Wegner *et al* 1998). In particular, when an idea such as male involvement challenges long held social concepts, community participation and ownership is even more critical to the programme success. Using satisfied clients as a means of promoting male methods is one method of fostering community participation. For example, the use of satisfied clients has been used in Sri Lanka, Mexico, Kenya and Pakistan (Finger 1998). Satisfied clients have most commonly been used for vasectomy promotion, to dispel men's fears and misconceptions about the method. For example, in Kenya, a group 17 of satisfied vasectomy clients, voluntarily formed community outreach groups to share their experiences with interested men and their partners, and to educate them about other family planning methods. Many of these men had not previously spoken publicly about their vasectomy experiences and a sense of solidarity soon formed within the group. Some men appeared in media campaigns, others volunteered at clinics to talk with men considering vasectomy and others worked with couples in outreach efforts. As a result of the groups' activities, men in the areas were much more likely to consider vasectomy, use condoms, and less likely to believe rumours associated with other methods (Finger 1998; Wegner *et al* 1998).

In Uganda, community participation in family planning programmes can be seen in a number of areas. As part of the Government's national HIV/AIDS prevention campaign, a music competition was launched called *Hits for Hope*. Young artists were encouraged to perform original songs with an AIDS prevention message. Teenage judges and the public selected the contest winners who recorded their song "Ray of Hope" in a professional studio, which was then used as part of a national mass media

campaign to raise awareness of HIV/AIDS in 1995 (Johns Hopkins 1995). Also in Uganda, a monthly feature in a daily newspaper, *Straight Talk*, provided young people with information and advice on sex and STI, including HIV/AIDS. Young readers were encouraged to engage with the feature through participation in quizzes, contests and reader surveys. Information was also provided by a sociologist and physician in response to readers' letters for advice (Henry 1995). A further initiative involved community leaders and respected older people (such as retired teachers and religious leaders) in a programme of sexuality education, which meant that the issue received the attention it deserved from male audiences (AVSC 1997). A large part of the success of these programmes is in involving the community and fostering a sense of ownership.

f) Couple Approaches

Increasingly researchers and providers of family planning services are coming to realise that it may be more appropriate to target couples for reproductive health information and services rather than the individual (Becker 1996). Research has shown that men who discuss family planning with their wives are more likely to use contraception and support their wives use of contraception (Drennan 1998; Becker 1996; Ndong *et al* 1999; Temmerman 1998; Hulton and Falkingham 1996). Furthermore, in Bangladesh, the *Jiggasha* project (meaning "to inquire" in Bangla), utilised existing social and communication networks to promote the discussion of reproductive health between couples. *Jiggasha* are village discussion groups composed of either men or women, who meet separately. These groups provide a comfortable setting for men and women to ask questions and discuss family planning, reproductive health and contraception. Trained field workers collaborate with *bari* heads (village leaders) to inform them about family planning methods, distribute contraceptives and make referrals. They also encourage men and women in the groups to communicate with their spouses about family planning. Men's participation in the *jiggasha* helps to create an environment of approval of family planning and surveys have shown an increase in the CPR amongst villages with a *jiggasha* (Johns Hopkins 1997). In Bolivia, the 1994 family planning campaign, "Let's talk together", sought to increase communication between couples. Over the period of the campaign the number of new contraceptive users and the number of men reporting their intention to seek reproductive health services increased dramatically (Ndong and Finger 1998)

4. Frameworks for the Delivery of Reproductive Health Services to Men.

Wegner *et al* (1998) report that there is no model for the provision of reproductive health services to men that is comparable to the constellation of obstetric and gynaecological services for women. In part this may be a reflection of the lack of definition of what comprises men's reproductive health care.

During 1997 the Association for Voluntary Surgical Contraception (AVSC) conducted a two-day workshop in Mombassa, Kenya, to identify a framework for reproductive health care for men. The workshop brought together teams of experts from more than a dozen African and Asian countries, including clinicians, counsellors, and social scientists with varied experiences in providing health and social service for men. The purpose of the meeting was to identify the core of basic reproductive health care services for men and to develop a model to serve as a framework for programme development and service delivery (Ndong *et al* 1999).

Participants agreed on four basic needs for men's reproductive health services. These are a) the need to assess current service provision to men and expand those areas deemed most appropriate, within resource constraints; b) the need to develop IEC strategies that promote the importance of men's reproductive health to improve that of women; c) the need to train health care workers in issues surrounding the provision of reproductive health services to men; and d) the need to create institutional linkages to other services both within the community and within the clinic (Ndong *et al* 1999). Identifying gender issues in the four areas above was also felt to be important. The framework suggested for men's reproductive health identified three categories of services central to men's needs;

- a) Screening and basic health services (such as contraceptive use assessment, and referral),
- b) Information, education and counselling services, and
- c) Clinical diagnosis and treatment services, for specialist needs.

Within these categories, services were further classified into clinic-based and those requiring referral.

In addition to three areas above, further areas identified as important included; men's roles in reproductive health, youth programmes, advocating for the inclusion of men's reproductive health in national guidelines, lobbying for resources (human, financial and material) to support initiatives, and addressing cost recovery and sustainability of initiatives at the outset (Wegner *et al* 1998).

The framework was reviewed by panellists who felt that it represented an ideal scenario and that its application to African and Asian settings must be considered within the context of existing health care delivery systems which face limited and diminishing resources. It was felt that a programme focussing on male services would only become sustainable if it was integrated into the existing female-oriented programme (Ndong *et al* 1999). The client centred approach to service delivery was also felt by some to be too daunting for newly developing programmes to adopt (Wegner *et al* 1998).

Although this model is not a blueprint of services, it represents a range of possibilities from which health services can adapt services to match their own priorities and resources. It is also the first comprehensive attempt to consider men's reproductive health needs within the framework of the health delivery system, and modifications will be required as the model is applied to real-world situations.

Currently, the AVSC is working with service providers to develop a reproductive health curriculum to train health workers in issues involved in serving male clients. When fully developed the curriculum will provide a guide for service delivery to men, which will encompass client and provider issues as well as organisational challenges of providing men's services within, and in relation to, female-centred health service delivery. The challenge of the training curriculum will be how it can be adapted to particular cultural and resource environments. The model will be piloted in two "real world" settings in the US and in Ghana, through three recently opened PPAG men's clinics in Accra (Ndong *et al* 1999). The programme will be launched and followed by an evaluation of the appropriateness of the model to draw out important lessons from this approach.

While the AVSC framework described above approaches service delivery to men from a providers perspective, a number of studies have identified service delivery issues from quality of care perspective, identifying the needs of the users themselves and the characteristics valued by male clients. In particular, Fapohunda and Ruttenberg (1999) identify the qualitative characteristics of a service delivery model, which incorporates the perspectives and preferences of men, their partners and service providers. Incorporation of these characteristics into the service delivery environment would encourage greater participation by men as both clients and supportive partners. The characteristics of family planning services valued by men in Kenya were reported to include providing;

- both family planning and STD services,
- a range of methods aside from condom and vasectomy,
- a guarantee of confidentiality, privacy and comfort,
- adequate access to information on methods, benefits and side effects,
- flexible hours and short waiting times,
- affordable services (free or minimally priced family planning methods),
- higher costs for STD services to encourage safe sexual behaviour,
- more male personnel to serve male clients,
- staff who are knowledgeable, friendly, patient, discreet, trustworthy and have good communication skills.

Similarly, work conducted in Zambia, Kenya and Tanzania (Population Council no date) which investigated men's barriers to using reproductive health services, identified that men encountered difficulties in three main areas. These were; poor *access* to services (physical access, lack of privacy, female only staff, restricted service hours and unfriendly providers); the *high cost* of services; and *lack of information* and choice of services. Men reported that an ideal reproductive health service for men should included the following attributes;

- respect for clients' privacy and confidentiality,

- a greater choice of male methods,
- services focussing on family planning and treatment for STI,
- knowledgeable, courteous, discreet, male providers,
- offer separate but equal services for men and women,
- keep flexible hours and short waiting times,
- be affordable, and
- offer community support.

As part of the study providers of reproductive health services were also asked what support they required to enable them to provide higher quality services to men and couples. The providers indicated that they need; to be kept informed of developments in men's reproductive health and service delivery strategies; more staff, particularly male providers; more space within clinics to accommodate male clients; training and support to provide vasectomy services; regular condom supplies; access to IEC materials aimed at men; and counselling skills for dealing with couple conflict resolution.

The AVSC framework and the identification of characteristics desired by male service users offer ways to conceptualise the delivery of reproductive health services to men. They also identify important interventions required by providers to make reproductive health services more acceptable and appropriate to men's needs.

5. Objectives of the Review Study.

The overall aim of this review study is to document current services and initiatives in the delivery of reproductive health services to men in Kenya and Malaŵi. There exists little comprehensive documentation of the current modes of reproductive health service delivery to men in the two study countries. This review study will provide an inventory of current initiatives in each country, which act as baseline information from which a larger evaluation study can be developed, to examine the effectiveness of specific types of services and modes of delivery. The specific objectives of the review study are to:

- a) conduct a literature review to identify any published work, ‘grey’ literature and on-going projects on reproductive health programmes for men in the study countries.
- b) develop an ‘inventory’ of current services / initiatives, in each study country, which target men in the delivery of reproductive health services.
- c) write a review document which summarises current initiatives / services and provides background information which can then be used for the development of a research proposal on the evaluation of RH service delivery to men.

The differing cultural, social, political and demographic backgrounds of Kenya and Malaŵi are likely to enrich the understanding of the appropriateness and effectiveness of reproductive health initiatives for men in different contexts. Due to its strategic importance in the East African Region, the openness of its politicians on population issues and the size of its population, Kenya has received substantial international aid and support for its population program since the 1960s. Kenya has transformed from being labelled the country with the highest fertility level in the late 1970s to one that has exhibited one of the fastest fertility transitions in human history. The Malaŵian Government, on the other hand, adopted an anti-natalist strategy that culminated in banning of family planning services between the 1960s and the mid-1980s. The family planning program appears to have gained momentum very rapidly, as evidenced by the notable decline in fertility and sharp increase in contraceptive use over the past decade. As with many other countries in the East-Southern Africa region, the two countries have been devastated by the HIV/AIDS epidemic. In 1997, approximately 15 per cent of Malaŵians were estimated to be infected with the HIV virus and nearly half a million people had died of AIDS since the start of the epidemic (World Health Organisation 1998).

This review study involved, first, conducting a review of published literature, reports and journal articles that focus on the delivery of reproductive health to men in each country. In order to gain a comprehensive view of the current status of service delivery to men it is necessary to review not only the published literature but also the ‘grey’ literature, which exists in the study countries. Such grey literature includes unpublished research studies, service evaluation reports, programme strategy documents, reports on current initiatives, policy documents and strategic plans for service delivery. This form of unpublished literature is generally not available through normal literature sources and therefore needed to be identified through meetings with service providers, researchers and other professionals involved in the provision of RH

in each country. Such meetings also enabled relevant ongoing research projects to be identified for which there may be no documentation available.

Second, a comprehensive ‘inventory’ of current services and initiatives that target men in the delivery of reproductive health services, was compiled. This involved a researcher in each of the study countries conducting meetings with the range of RH service providers and recording any initiatives developed specifically for service delivery to men. Meetings were conducted with a range of Government ministries, national and international non-government organisations (NGOs), service providers, mission and charity organisations (particularly those focused on promoting HIV/AIDS awareness), commercial enterprises and international donor agencies (ie: DFID, USAID). A full list of organisations visited in each country can be found in appendix A. For each service or initiative identified, information was collected on the operational details, including; the aims of the service/initiative, target group, coverage of services, types of services provided, funding, staffing, client information, and monitoring/evaluation of the service. This information was then synthesised by mode of delivery (static services, IEC strategies, outreach or research/evaluation studies) to provide a broad overview of the initiatives in each country. This review document will provide the basis for developing a research proposal to evaluate effective modes of reproductive health service delivery to men in the African context.

6. Review of Initiatives in Malaŵi.

NOTE: the documentation collected from institutions in Malaŵi has not yet been received.

Both the public and private sectors are important in supplying family planning services in Malaŵi. The key organisations that have established initiatives for providing reproductive health services to men in Malaŵi include; Banja la Mtsogolo, the Family Planning Association of Malaŵi, the Ministry of Population and Health, as well as a range of non-Government organisations (ie: Population Services International, ADRA).

Among the private sector providers one of the key organisations is Banja la Mtsogolo (BLM). BLM is a large and successful non-government organisation (NGO) which was established in 1987 with financial and technical support from Marie Stopes International (London). It was established to complement the Government's efforts in the provision of reproductive health. BLM provides reproductive health services through its clinics, which are located urban areas nation-wide. The number of BLM clinics is rapidly expanding, 17 clinics were operating in 1997 and it is expected that 31 clinics will be in operation by 2000. BLM is an important provider of family planning services in Malaŵi, it is reported to account for 61% of the market share in 1998, an increase of 22% since 1997. While government facilities (district hospitals and health centres) generated 237,117 couple years of protection (CYP) in 1998 through the provision of contraceptive supplies, BLM generated 378,620 CYP (Banja la Mtsogolo 1999).

Although BLM provides family planning services for all members of the community, they provide a number of important initiatives that specifically target men. At static clinics reception staff are trained on serving male clients, and give men priority treatment to overcome the possible discomfort of accessing the service. The main initiatives for men, however, are in the outreach services, in particular the *Man to Man* programme. *Man to Man* is an outreach service providing family planning information and services to men at their workplaces. BLM does operate workplace schemes that target all interested workers (men and women), but the *Man to Man* initiative is specifically targeted at men. This initiative has wide geographical coverage and operates within six districts in four zones of Malaŵi (Blantyre, Zomba, Lilongwe, and Mzimba). In rural areas a similar initiative operates through village chiefs, reaching men in public places (ie: beer halls, markets, clubs) in addition to workplaces. These programmes have been very active during 1990 to 1996, however, focus is now on CBD and programmes for youth, due to a shift in donor priorities (UNFPA and the EU). The youth initiative targets men and women aged 14-25 through youth clubs in 17 districts in Malaŵi. Youths are trained as CBD workers to distribute methods and refer peers to BLM clinics. This initiative is funded to operate from 1997 to 2001.

The newly established Family Planning Association of Malaŵi (FPAM) was established in 1999, and is expected to operate for five years. The FPAM replaces the former Family Welfare Council of Malaŵi under which a number of family planning

initiatives were developed. Due to its recent development, the FPAM is currently developing strategies and operational structures. The FPAM intends to provide family planning clinics nationally within nine established zones, and plans to construct one clinic per year in each zone. The main donor for the operation of the FPAM is the IPPF, with additional support from UNFPA and the EU. The initiatives currently operating focus on providing information to advocate family planning use and operating a workplace outreach scheme. The workplace scheme is not exclusively for men, however, many men participate in the sessions. The information sessions focus on HIV /AIDS prevention and awareness as well as family planning. Workers are referred to health centres to obtain contraceptive supplies. It appears that there is some duplication in the workplace initiatives of BLM and the FPAM.

The Ministry of Health and Population (MOHP) is committed to improving access of family planning services to all individuals, and men have been identified as one specific target group. The reproductive health programme at the MOHP began in the early 1980s. The MOHP provides an integrated programme of reproductive health services, including; family planning services, STI/HIV counselling and treatment, safe motherhood and youth initiatives. The MOHP provides reproductive health through hospitals, clinics, schools and in the community, through community based distribution agents (CBDA). Health personnel are trained through the MOHP and contraceptive supplies are provided to hospitals and clinics. In addition, the reproductive health programmes works with 80 CBDA, 30 of which are men. The MOHP has also been responsible for co-ordinating activities of the former Family Welfare Council of Malawi to produce IEC materials on family planning for men. It is intended that these materials will be used by government departments, community based distributors and community leaders in advocating male involvement in family planning. The MOHP is currently developing the first national reproductive health policy.

In addition to the three main providers of reproductive health services, identified above, there are a range of NGOs that provide services targeting men. The initiatives of NGOs are primarily focussed on providing information and/or outreach activities. Each NGO has its own focus, either on reproductive health or on HIV/AIDS awareness and services. The outreach services of many NGOs utilise male CBD agents, male motivators, and male peer educators to reach men in the community. Two organisations are of particular note; first, Population Services International (PSI) is a social marketing organisation which has developed one of the leading commercial condom brands in Malaŵi – *Chishango*. PSI has a particularly active marketing campaign in both urban and rural areas. It has also initiated innovative outreach schemes such as the *Chishango Trophy*, whereby annual sporting events (football, basketball, netball) are hosted and the *Chishango* trophies awarded. At these sporting events HIV/AIDS awareness messages are given, condoms are promoted and a range of IEC materials are distributed to spectators and participants. PSI also initiated a workplace scheme, which was unsuccessful due to PSI's cost-sharing mode of operation. The Adventist Development and Relief Agency (ADRA) is another organisation worthy of note due to its outreach work which has targeted population sub-groups, many of which are male dominated. The organisation's IEC programmes targets groups at high risk of STI/HIV transmission, who may not be accessible through health services, including truck drivers, prisons, army, tertiary students,

commercial sex workers and traditional healers. ADRA is funded by the Danish Embassy.

The majority of strategies which target men in Malaŵi are focussed on outreach services or information. Although some attention has been given to training staff at static clinics in issues of serving male clients, the majority of initiatives are focussed on outreach strategies to access men. In particular, initiatives have focussed on the delivery of reproductive health information and services through workplace schemes, the use of male motivators and male CBD agents who operate within the community. Although workplace schemes are often urban based a number of organisations have developed similar schemes in rural areas, which operate through chiefs and focus on men's groups as well as places of employment. Radio is a common form of IEC for generic reproductive health messages and HIV/AIDS awareness campaigns, some of which have specific messages for men. Table 1 and the summary below give an overview of current modes of delivery (information, education, communication (IEC); outreach; static services and research) for the reproductive health initiatives targeted to men in Malaŵi.

1. Information, Education and Communication (IEC)

Both government and non-government organisations conduct information, education and communication strategies about reproductive health and HIV awareness. The IEC materials and campaigns have differing target groups, which include; generic campaigns for the general community, which may have a male component; focus on adolescent sexual and reproductive health; or specific HIV/AIDS awareness strategies which have indirect messages for contraceptive use. The most prominent forms of IEC in Malaŵi include;

- a) Radio: Jingles, soap episodes, programmes and announcements on reproductive health. Most have generic reproductive health messages (eg: BLM's programme: *Let's Start Family Planning*). The Ministry of Information develops reproductive health messages specifically targeted towards men and the Ministry of Gender, Youth and Community Services has developed a radio programme (*Straight Talk*) on sexual and reproductive health of youth.
- b) Drama: Puppetry, drama, and music are used as a medium for delivering reproductive health messages to men. These media are often used in workplace schemes (eg: puppet shows for BLM's *Man to Man* programme), in youth outreach programmes and in community information schemes in rural areas.
- c) Discussion: Group discussions on reproductive health and counselling are conducted as part of peer education at youth groups and community outreach programmes targeting men's groups.
- d) Educational Materials: Include posters, flip charts, fact-sheets, newsletters, calendars, caps and T-shirts (eg: *I'm a Volunteer*). The Ministry of Health and

Population produce IEC materials targeted at men for use by CBD workers and community leaders to advocate for male involvement in family planning.

- e) Events: PSI holds annual sporting competitions (football, netball, and basketball) and presents *Chishango* trophies. During the matches IEC materials are distributed and public talks are given which promote condom use and HIV/AIDS awareness to participants and spectators.

Radio messages about family planning often do not reach rural areas. To promote family planning and reproductive health in rural areas a range of organisations (PSI, Ministry of Information, Ministry of Gender, Youth and Community Services and ADRA) provide IEC directly at the villages. Mobile video units are taken to rural areas to promote condom use (PSI); drama and music artists travel through rural areas to conduct performances with reproductive health and HIV awareness messages (Ministry of Information), traditional leaders are trained to provide information on HIV risk to the surrounding communities (ADRA) and out of school youth in rural areas are provided with sexual and reproductive health information (Ministry of Gender, Youth and Community Services).

2. Outreach Services and Information

The delivery of reproductive health services through outreach modes of delivery is the most common form of provision of sexual and reproductive health information and services to men in Malaŵi. Both Government and NGOs conduct outreach delivery of reproductive health. Some outreach initiatives target men specifically, while others are inclusive of men by providing outreach services for both men and women. The types of outreach services providing reproductive health for men in Malaŵi include;

- a) Workplace Schemes

Workplace schemes were initially designed as a strategy to target men in their places of employment to provide information on sexual and reproductive health (SRH). The most well known in Malaŵi is the *Man to Man Programme* developed by BLM, which is designed as a male only initiative to provide SRH information to men in workplaces as well as men's clubs. Although workplace schemes were developed to target men, not all workplace schemes are exclusively for men, some now provide information for all workers. Workplace schemes are implemented in government organisations as well as private companies, agricultural and industrial enterprises. They therefore generally operate in major urban areas (ie: Lilongwe, Blantyre, Zomba, Mzuzu). Workplace schemes are operated by BLM, Family Planning Association of Malaŵi and the National Association for People with HIV/AIDS Malaŵi (NAPHAM). The NAPHAM scheme however, is focused specifically in HIV/AIDS awareness and support. In general, the providers of workplace schemes will directly provide the first information session in the workplace, they will then train key employees (eg: planning officers) who will deliver subsequent sessions on a regular basis within their own workplace.

A number of NGOs (HOPE and ADRA) operate workplace schemes that target specific occupational groups. These occupations are mostly male dominated or

comprise groups who may be at particular risk of STI or HIV infection. HOPE operates workplace schemes for all workers in the tea and rubber plantations in four districts in Malaŵi. ADRA provides workplace information to specific groups including, truck drivers, prisons, army personnel, commercial sex workers, tertiary students and traditional healers.

b) Outreach in Rural Areas

Providers of workplace schemes in urban areas have applied the concept of the workplace scheme in rural areas. In place of operating through institutions, the scheme operates through chiefs who arrange community forums, some of which are in working environments, others in community settings. These groups then receive the same information as in the urban workplace scheme and are referred to local health services for support.

c) Male Motivators

Male motivators are community members trained to provide information on reproductive health to men in their own communities. They are trained to provide information on male methods (ie: condom and vasectomy) and to encourage the adoption of family planning amongst men in the community. Motivators also provide reproductive health information to men at church groups, market traders and sports teams. They also refer men and couples to family planning clinics to obtain methods or services. In general, motivators do not distribute contraceptive methods, but may provide condoms upon request. Some religious / traditional leaders are trained as motivators and counsellors, particularly for HIV/AIDS. The government Ministry of Gender and Community Services trains male (and female) motivators, as well as do a range of NGOs including; CHAM, Save the Children, ADRA and NAPHAM. The NGOs providing training for male motivators often cover a limited geographic area, for example, Save the Children trains motivators in Balaka district only, CHAM in Ekwendini Hospital catchment area and ADRA only in Mwanza.

d) Male Community Based Distribution Agents (CBDA)

Male (and female) CBDAs work in communities to distribute contraceptives (usually pill and condom), provide reproductive health information and refer clients and couples to services. They differ from motivators in that they actually distribute contraceptive methods. Male and female CBDAs are trained by government agencies including; the Ministry of Gender, Youth and Community Services, the Ministry of Health and Population and the Family Planning Association of Malaŵi. Plan International also trains CBDAs.

e) Male Youth Peer Educators

Male (and female) youth aged under 25 are trained as peer educators to work in communities to provide information to their peers about STI and HIV transmission

and to refer youth to sexual health services. Youth peer educators provide information in forums such as youth clubs, schools and sporting events. Information about HIV/AIDS awareness and sexual health is provided through discussions, debate, drama, and videos. The Family Planning Association of Malaŵi trains youth peer educators, as do a range of NGOs including, BLM, Save the Children, ADRA and HOPE.

3. Services for Reproductive Health

Clinic based services for reproductive health are provided by two main organisations in Malaŵi, the Family Planning Association of Malaŵi (FPAM) and BLM. In addition the Youth Council of Malaŵi provides a youth clinic in Lilongwe. BLM provides static clinics that provide reproductive health services for both men and women. Reception staff at the clinics are trained to provide male-friendly services. Aside from this no other male initiatives are provided at the static clinics, male initiatives are provided through the workplace schemes and the *Man to Man* programme (described above). The FPAM is planning to construct clinics nationally during the next five years, there is currently no strategy in place to provide male-friendly services at the clinics, initiatives targeted towards men are provided through FPAM workplace schemes.

Contraceptive supplies are distributed to providers (eg: hospitals, clinics, schools and community distributors) by the Ministry of Health and Population, and PSI distributes *Chishango* condoms to outlets nationally.

4. Research and Evaluations

There exists little available research which evaluates service delivery initiatives to men in Malaŵi. PSI conducts regular and in-depth evaluations on the impact of its own media and IEC campaigns on consumers, and consumer profile surveys and outlet surveys to identify user perspectives of condoms and the PSI *Chishango* condom.

Has BLM or MSI evaluated the *Man to Man* scheme??

Table 1: Summary of Initiatives for Reproductive Health Services for Men in Malaŵi.

Organisation	Information & Education	Outreach	Service	Research
Banja La Mtsogolo (BLM)	Radio programmes <i>Tiyambe Zakulera</i> (“Let’s start Family Planning”) and <i>Millenium Youth</i> . Promotes FP but not specific to men.	Workplace schemes in government and private companies. Target all workers. Use IEC materials – drama, video, poems, posters, and leaflets. Community outreach workers are proactive in approaching companies. Coverage is Blantyre, Zomba, Lilongwe and Mzimba. Uptake is low amongst Asian-run companies. Outreach in rural areas through Chiefs who arrange community forum. MAN TO MAN: Info on RH targeted to men only, through workplace, men’s clubs etc. Use IEC materials. Also in rural areas through chiefs. Funded by UNFPA. Youth Outreach: target men/women 14-25 years. RH info to youth through youth clubs in 17 districts. Rural areas operate through MOH sub-clinics.	Static Clinics. RH provision, receptionists trained on male friendly services. STI treatment, condom, vasectomy services.	

Table 1: Initiatives in Malaŵi contd...

Organisation	Information & Education	Outreach	Service	Research
Family Planning Association of Malaŵi		Workplace scheme for all workers in industries, private and commercial companies. Will expand to civil servants. Conduct training of planning officers who continue training using workplace resources. Very similar to BLM workplace scheme. CBDA and youth used in community to advocate for RH – no details.	Developing static clinics in each of 9 zones in Malaŵi which provide IEC, counselling, advocacy, SRH services.	
Christian Hospitals Association of Malaŵi (CHAM) - Ekwendeni Mission Hospital		218 volunteer male motivators to encourage use of condoms and vasectomy, couple counselling, 60 male monitors conduct talks to men in villages. These are not CBDA but refer men to clinics for contraceptives. Target area Ekwendeni catchment area.		
Health Opportunities for People Everywhere (HOPE)		STAFH Project (Support to AIDS and Family Health). Information on FP, STI, HIV/AIDS to tea and rubber estate workers in 4 districts (Zomba, Thyolo, Nkhoskhota, Nkhata Bay). Youth also targeted through schools that serve estate populations.	.	

Table 1: Initiatives in Malaŵi contd...

Organisation	Information & Education	Outreach	Service	Research
Ministry of Gender, Youth and Community Services	SRH information for out of school youth aged 10-25, mainly rural areas (male and female). Coverage 10 districts. Youth outreach campaign using peer education, drama, discussion, distribute condoms and counselling. Also establish youth centres where SRH info shared. Radio programme <i>Straight Talk</i> developed on adolescent sexual health.	CPEP (Community based population education project) Train community development assistants (CDA) and social welfare assistants (SWA) to provide RH information to church groups, committees, schools market traders, sports teams etc. Not specifically for men. Training of 45 CBDA (male/female) in three districts (Mzimba, Zomba, Ntchisi). Focus on counselling, referral to RH services, advocacy of FP, distribute pills and condoms.		
Ministry of Information	Mass media on RH Project: produce radio programmes (jingles, magazine program, soap episodes) on aspects of RH. Special messages for men included. Drama and music media used in rural areas, unreached by radio. Plays focus on men. Artists stay in villages for one month.			

Table 1: Initiatives in Malaŵi contd...

Organisation	Information & Education	Outreach	Service	Research
Ministry of Health and Population	Produce IEC materials for men (through former National Family Welfare Council of Malaŵi). Posters, poems, jingles, fact-sheets, advocacy of condom and vasectomy. Targeted to men, service providers, youth, traditional leaders, teachers, religious leaders, and parents. Channelled through government and CBD and leaders – was this done??	CBD (50 women, 30 men) distribute contraceptives, provide counselling on STI/HIV and referral.	Provide FP and RH through hospitals, clinics, schools and community. Ministry provides training for FP providers in hospitals and contraceptive supplies (pill, condom, IUD, injectables, sterilisation and vasectomy).	Feasibility of implementing district-wide CBD for FP services to increase contraceptive uptake. a) Baseline survey (3 study / 3 control sites) on RH use. b) Evaluation survey to identify changes in target indicators. Focus on women and household surveys. Improving Access to SRH services by Adolescents in School. - identify obstacles faced by adolescents in accessing in obtaining SRH services.
National Association for People Living with AIDS in Malaŵi (NAPHAM)		Education outreach campaign. NAPHAM trained 36 volunteer to conduct education campaigns on HIV/AIDS awareness in schools, workplaces, and in the community. In workplaces use peer education – key people are trained and continue to disseminate messages. Not targeted specifically at men.		

Table 1: Initiatives in Malaŵi contd...

Organisation	Information & Education	Outreach	Service	Research
Plan International	HIV/AIDS and STI initiative. Use health workers to produce IEC materials – plan to produce calendars, posters, brochures, newsletters. Male/female CBD in Lilongwe to advocate and refer to clinics.	Train men/women as CBD of contraceptives and referral to services. Coverage: rural and semi-urban areas of Kasungu, Lilongwe and Mzimba.	Distribute <i>Chishango</i> condoms through shops nationally.	Condom distribution survey. Condom consumer profile survey.
Population Services International	IEC campaign to prevent HIV/AIDS: radio jingles, posters, leaflets, T-shirts and caps. Also video units visit rural areas. PSI assists 6 local drama groups to spread HIV/AIDS awareness messages.	<i>Chishango Trophies</i> for annual football, netball and basketball competitions. HIV messages and public talks given at gatherings. Workplace scheme (not specific to men) unsuccessful due to PSI cost sharing operation.		
Save the Children USA		Train 20 male motivators who advocate FP to men in the community, homes, clubs etc to distribute condoms and provide referral. In Balaka district only. <i>Nchanda ni Nchanda pa Umi wa Mbone</i> (Youth to Youth for Health Life) a) Recruit and train youth CBDA (m/f). b) Train religious/traditional leaders including male initiation counsellors on STI, HIV/AIDS.		

Table 1: Initiatives in Malaŵi contd...

Organisation	Information & Education	Outreach	Service	Research
Youth Council of Malaŵi	Information on RH provided to youth (male/ female) through registered youth organisations. Provide 2 weeks life skills training.		Youth clinics opened (FPAM, Queens Hospital). Youth consultative meetings held in Lilongwe hospital.	Task force formed to identify how to develop youth friendly RH services.
Adventist Development and Relief Agency (<i>AIDS and Modern FP Project</i>)	HIV/AIDS outreach campaign in rural areas. Motivators give information to men/ women on risk behaviour of traditional practices and HIV/AIDS; - sharing razors in initiation - sexual cleansing - initiation songs IEC on FP HIV/AIDS and cultural beliefs, posters, brochures, radio programme <i>Tikuferanji?</i> (Why are we dying?)	Volunteer motivators (19 men / 31 women) operate through MOH and CHAM clinics to promote FP. Are not CBD agents but refer clients to clinics for FP. 1 team of male motivators in Mwanza. Youth outreach: in-school AIDS clubs conduct sporting activities (football, netball) during half-time conduct discussions on HIV/AIDS. Out of school youth: hold discussions, debate, poems, drama, dance to promote HIV/AIDS awareness. Information on RH and HIV/AIDS to: - Truck drivers at company sites, truck stops, borders. - Prisoners - Army personnel - Tertiary students – peer education, free condoms - Commercial sex workers – female bar-workers conduct community meetings using IEC materials - Traditional healers trained as peer-educators. Coverage: all southern and 3 central districts.		

7. Review of Initiatives in Kenya.

Sixty percent of health care services in Kenya are provided by the government, with the remaining 40% provided by NGOs including religious organisations and the private sector (NCPD 2000). The majority of reproductive health outlets in the country are in maternal /child health and family planning clinics. These clinics have been established in all public hospitals, health centres and many dispensaries. Through these outlets the public health sector provides 68% of all family planning services in Kenya (*ibid*). Curative services for sexually related gynaecological problems are provided through maternity units and gynaecology/urology and other outpatient clinics within public hospitals and health centres. Family planning services provided through government institutions are free of charge. The National Population Policy for Kenya identifies that men are currently under-served and inadequately targeted by reproductive health programmes, and highlights the urgent need for men to be involved in all population programmes (*ibid*).

There exist a wide variety of organisations providing family planning services in Kenya. The key organisations that have established initiatives for providing reproductive health services to men include; the Ministry of Health, Family Planning Association of Kenya, Family Planning Private sector as well as a range of non-Government organisations.

The Ministry of Health is the largest provider of family planning services in Kenya. The Ministry provides family planning services for men and women nation-wide through static clinics, hospitals and maternal / child health facilities. The initiatives undertaken by the Ministry specifically to target men, include; providing training for male personnel in the delivery of reproductive health to men; provision of CBD agents to provide family planning services, information and referral to Marie Stopes clinics for vasectomy services; developing a range of IEC materials (including radio broadcasts) advocating family planning use amongst men, and; providing treatment for STI and infertility for men.

The Family Planning Association of Kenya (FPAK) was established in 1962, and has been a pioneer of family planning service provision. The FPAK has grown to be the largest non-government provider of family planning services in Kenya, and is now described in the 1998 Kenya DHS report as second only to the Ministry of Health. The FPAK operates a range of strategies to provide reproductive health services to men, including developing IEC campaigns directed towards men, recruiting community health volunteers to work in rural areas and advocate for family planning use amongst men, and training service providers in service delivery to male clients. However, the most comprehensive programme of reproductive health service delivery to men in Kenya is provided through the FPAK's strategy, "Reaching out to Men: the Forgotten Fifty- Percent". As part of this strategy the FPAK developed the *Male Involvement Project* (MIP), which has the purpose of trying to reach men with both reproductive health information and services. It combines service delivery through male-only clinics with a multi-media IEC community mobilisation strategy. The MIP implemented a range of strategies to improve the quality of reproductive health services for men in three districts (Kakamega, Nakuru and Kisumu), the strategies include; the establishment of male-only clinics, training of workplace motivators, development of IEC materials, and advocacy of condoms and vasectomy. The project

is supported by a grant from the IPPF Vision 2000 fund, and has been in operation from 1995- 2000. Of particular relevance to the current review study is the evaluation of the MIP, which is described in a following section of this report.

The Family Planning Private Sector (FPPS) is a non-government organisation, which assists the private sector and other non-government organisations to provide family planning services more effectively or to upgrade their skills in service delivery. The FPPS assists service providers in the delivery of reproductive health services through the following;

- developing IEC materials for distribution nationally to providers of reproductive health services;
- providing training for service providers, particularly training of trainers on male motivation, and training in use of puppetry in community education;
- providing IEC (particularly puppetry) and training on behalf of other providers of family planning, for example, FPPS runs puppet shows on male involvement in family planning for FPAK's outreach programmes, and
- training of CBD agents and HIV/AIDS counsellors, in conjunction with Family Planning Logistics Management (FPLM).

In addition to the providers of reproductive health services described above, there exists a large number of NGOs that provide reproductive health to men through outreach services. Some of these initiatives include; training of peer motivators to work amongst sex workers, community groups and in youth clubs (Family Health International); providing information through outreach strategies which target men in schools, churches, men's organisations and chiefs *barazas* (Christian Mission Aid). Men are also targeted through community sporting events such as the *Challenge CUP* conducted by AVSC, whereby reproductive health information is provided to participants and spectators at these events. The initiatives of many NGOs are more limited in their geographic coverage than those of the key service providers described earlier or they focus on a specific target group. For example, some initiatives focus on slum dwellers (Pathfinder), beach workers in Mombassa (ACE Communications), Eastlands estate area in Nairobi (FPLS) and the promotion of vasectomy in Vihiga (AVSC).

There also exists in Kenya a significant number of initiatives developed for the mass media, which promote male involvement in reproductive health or focus on HIV/AIDS awareness and the promotion of condom use. A range of organisations have developed radio programmes, topical videos, docu-dramas, and advertisements and promotional campaigns for television.

The initiatives developed in Kenya to provide reproductive health services to men use a variety of service delivery modes including; IEC, outreach and service provision, including male family planning clinics. These initiatives are summarised by mode of delivery in Table 2 and the summary below.

1. Information Education and Communication (IEC)

Information, education and communication strategies about reproductive health and HIV/AIDS awareness are conducted by the Family Planning Association of Kenya (FPAK) and a range of NGOs (FPPS, PSI, AVSC and PATH). The IEC materials and campaigns are directed at various target groups, including; reproductive health messages for the general community, messages specifically for men or adolescents, and specific HIV/AIDS awareness campaigns promoting condom use. The most prominent forms of IEC for reproductive health and HIV/AIDS awareness in Kenya include;

a) Media: Radio (eg: PSI's *Trusted Partner* campaign and FHI's *Ask Me* slogan), television, films (eg: Pathfinder's *Yellow Card* film), video (Kabiro Health Trust's video *Consequences*), cassettes and docu-drama.

b) Reference material: Calendars, wall-charts, and booklets which are used by community based distributors and peer educators.

c) Drama: Puppetry, folk media, music and dance, poetry, story telling. Drama is used to convey reproductive health messages in a light-hearted manner. For example male staff members of the FPAK clinic put on puppet shows in the local park at lunchtimes. The puppets are seen as an entertaining, non-threatening way to educate both men and women about contraceptive methods, STI/HIV prevention, and available services. At the end of each show the puppeteers invite questions from the audience. Music festivals have also been organised which promote condom use and HIV prevention.

d) Promotion: Newspaper postings, wall posters, billboards, banners, car stickers, T-shirts, caps, key rings, coasters and campaign slogans such as PSI's *Let's Talk* and *Talk to Me* for the promotion of *Trust* condoms.

The IEC campaigns which have specifically targeted men tend to have a greater focus on the use of puppetry, folk media, story telling, arts, drama, music and dance. These modes of delivery are also used most often to provide reproductive health information to youth but a stronger focus is given to film, video and docu-drama for this target group.

We have no information about IEC in rural areas in Kenya.

2. Outreach Services and Information

Both Government and NGOs conduct outreach delivery of reproductive health. Many of the outreach initiatives are specifically designed to reach men in the community. There are numerous types of outreach services that provide reproductive health services or information to men in Kenya, these include;

a) Workplace schemes

Workplace schemes operate in public and private sector organisations to provide workers, particularly men, with information and services on reproductive health and STI/HIV information. Workplace schemes typically operate through workplace motivators who are trained in peer motivation and reproductive health by an outside organisation, such as the FPAK or FPPS. Workplace motivators provide information sessions, counselling and distribute family planning methods to workers. Workplace motivators teach fellow employees at lunch times and at after work seminars about contraception, birth spacing, and HIV/AIDS. They sell contraceptives, (pill and condom) to men after work. They also visit employees' houses in factory compounds to answer questions from men or couples and assist them to make reproductive decisions together. They also refer clients to the FPAK clinics for vasectomy or tubal ligation.

Although the workplace schemes in Kenya are not exclusively for men, a significant proportion of the participants are males. Organisations involved in initiating workplace schemes and providing training for motivators include, FPPS, FPAK, FHI and Pathfinder International. The FPAK currently conducts workplace schemes in 90 companies and FHI in 45 companies.

b) Male Community Based Distribution Agents (CBDA)

Men are trained as CBDA to provide reproductive health information, referral, and contraceptives to other men in their communities and the informal sector (eg: market traders). Most male CBDA work in their own communities in urban areas, some work in rural areas, while others work in specific areas such as the estates of Nairobi to target young men in slum areas. Organisations which are involved in the training and support of male CBDA include the Ministry of Health and a range of NGOs, such as FPPS, FLPS, Pathfinder, Plan, MYWO and Kabiro Health Trust.

c) Male Peer Educators

Male peer educators are trained to promote HIV/AIDS awareness and provide reproductive health information in their own communities amongst their peers – adolescents and men. Peer health educators mobilise men in the community into discussion groups to provide information and advocacy on family planning use. For example, vasectomy groups to inform men of the realities of the procedure, university discussion groups for sexual and reproductive health information and meeting with men at the chief's *barazas* (men's groups) to advocate for family planning. Adolescent peer education is conducted in schools, youth clubs and in slum areas amongst unemployed youth. Youth peer educators conduct meetings, show videos and drama which provides detailed information about condom use and sexual health. Male community health volunteers work in rural areas to encourage men to adopt family planning methods and to refer them to family planning services. The FPAK is involved in utilising peer education for men's reproductive health promotion, as well as a large number of NGOs including; FPPS, AVSC, FHI, Ace Communications, Pathfinder International, Plan International, MWYO and the Kaibiro Health Trust.

d) Community Advocacy

Community advocacy for family planning use amongst men involves utilising existing community organisations and locations where men gather as for a for providing information on reproductive health and advocate for family planning use. Such advocacy involves visiting men's organisations, sporting clubs, barazas, church groups and community leaders or focusing on community sub-groups such as beach workers (ie: fishermen, traders, sex workers). The focus of these community advocacy initiatives has been primarily to promote HIV/AIDS awareness, through music, drama and video. AVSC has conducted sporting events, such as the *Challenge Cup*, to provide information about reproductive and sexual health to participants, many of who are men.

e) Training of health professionals

Training of health professionals to provide reproductive health information and services for male clients is conducted by AVSC and the FPPS. Peer educators and community motivators are also trained to work in the community or amongst community sub-groups (youth, sex workers, traders) to provide reproductive health information to men.

3. Services for Reproductive Health

a) Family planning clinics

Static clinic services for family planning and reproductive health are provided by the Ministry of Health, FPAK, Marie Stopes, and CHAK mission hospitals. These clinics provide reproductive health services for both men and women. The Ministry of Health provides training for male personnel in reproductive health and the FPAK provides training for reproductive health service providers on the provision of services to male clients. Many of these initiatives focus on male only clinics or outreach programs for men rather than initiatives at static clinics. The Contact Resource Service also provides a consultancy service for reproductive health service providers to train counsellors and doctors in service delivery to men.

b) Male Clinics for Reproductive Health

Male-only clinics for sexual and reproductive health provide clinical and social services. The FPAK male clinics offer; individual and couple counselling (advice on infertility, loss of libido, premature ejaculation, and prostate cancer), inter-spousal and interpersonal communication, STI information, counselling, screening and laboratory facilities for testing. Male only clinics are operated by a range of organisations;

FPAK	Clinics in three districts (Nakuru, Kakamega and Kisumu).
AVSC	Clinic in Nairobi.
CHAK	Clinics within mission hospitals

Marie Stopes Clinics in Nairobi.

We have little further information about the operation of male only clinics.

c) Youth Clinics for Sexual and Reproductive Health

Youth clinics are provided by the FPAK, in collaboration with other organisations, in Nairobi and Mombassa which cater for the sexual and reproductive health needs of young men and women.

d) Workplace Clinics

Barclays Bank and East Africa Industries operate workplace clinics that cater for the sexual and reproductive health needs of male workers. They provide condoms, HIV/AIDS counselling and referral to family planning clinics. Male counsellors are provided for male workers.

e) Provision and Distribution of Condoms

A range of NGOs provide and maintain commercial condom dispensers in workplaces and public places, these include AVSC, Barclays Bank, East Africa Industries, PSI, Pathfinder, Plan International and Kabiro Health Trust. Kabiro Health Trust provides condom dispensers in slum areas, hair salon areas, video houses and pool halls.

f) HIV Testing and Counselling

A number of agencies provide support services to men and couples for HIV testing and counselling as well as advice on reproductive health issues (WOFAK, FPLS, Nairobi Council Specialist Treatment Centre).

4. Research and Evaluation

A number of research outputs exist which focus on the provision of reproductive health services for men in Kenya. Many of these studies investigate aspects of the service delivery process and the barriers faced by men in utilising RH services. These include;

a) The AVSC developed the *Men as Partners (MAP)* initiative in 1996 to assist service providers, policy makers and donors create programmes that constructively involve men in reproductive health (AVSC 1998). The AVSC conducted a MAP workshop in 1998 to provide a forum for discussion on the activities and initiatives towards improving reproductive health service delivery for men in Kenya. Issues were discussed under the themes of research, communication and service delivery.

The AVSC has also developed a more universal framework for conceptualising men's reproductive health needs to provide a range of options for providers when establishing or refining reproductive health services for men (outlined earlier in this document). The AVSC has also developed a strategy for providers of reproductive health to obtain feedback from users on the quality of services. This strategy is called Client Oriented Provider Efficient (COPE).

b) Research to investigate strategies which increase male utilisation of reproductive health services, barriers experienced by men in service use and components of male-friendly services have been conducted by a number of organisations including, PATH, Population Council, Family Planning Association of Kenya and African Population and Health Policy Research Centre (APHRC). The characteristics valued by male clients in family planning service provision and the perspectives of service providers in quality of care in service delivery to men have been outlined earlier in this document.

c) Population Services International conducts regular monitoring and evaluation of the impact of its own media promotion campaigns on consumers, and on the effectiveness of marketing strategies of PSI *Trust* condoms. PSI conducts *Trust* distribution surveys, mass media surveys of campaigns, annual consumer profile surveys and outlet surveys to identify user perspectives of condoms and the PSI *Trust* condom.

d) The research most relevant to the current study is the evaluation of activities conducted in the Family Planning Association of Kenya's *Male Involvement Project* (MIP). The MIP is a five-year project initiated in 1995 with funding from the IPPF, and is being implemented in three districts in Kenya, Nakuru, Kisumu and Kakamega. The goal of the project is to increase male involvement and participation in family planning and other aspects of reproductive health. The objectives included specific targets for; an increase in the use of male methods, a reduction in TFR, an increase in use of modern methods of contraception, an improvement in spousal communication, and the provision of information and advocacy for family planning. The MIP implemented a range of strategies to improve the quality of reproductive health services for men, these include;

- a) Establishment of male-only clinics,
- b) Training of workplace motivators,
- c) Development of IEC materials, and
- d) Advocacy of condoms and vasectomy.

An evaluation of the project was integral to the project design. The aim of the project evaluation was to review and document the programme's achievements measured against the project objectives and the findings of a baseline survey. A number of areas were evaluated – services, IEC, community impact (knowledge, attitudes and practice), financial and managerial indicators. The project comprised a household baseline survey conducted in 1995, followed by a further household survey in 1999. The evaluation methodology used a number of instruments including; a knowledge

test questionnaire for workplace motivators, clinic exit surveys from the male clinics, an effectiveness questionnaire on the IEC materials used, focus group discussions and in-depth interviews.

Results of the evaluation show that the MIP has been successful in achieving many of the target objectives, in particular;

- An overall increase in the prevalence of condom users from 17.6% in 1995 to 26.4% in the three study districts. The highest total increase in condom use was seen in Kisumu with an increase of 11.9%. An increase in the number of vasectomy clients from 4 in 1995 to 41 in 1998, an increase of 32%.
- A decrease in TFR from 5.4 in 1995 to 3.7 in 1999.
- An increase in the proportion of respondents using a modern method of contraception from 39% in 1995 to 43.1% in 1999.
- Increased awareness of male family planning clinics, 30.6% of men had heard of male family planning clinics in 1995, this increased to 70% by 1999. Similarly, 3.5% of males had visited a male only clinic in 1995 this increased to 6.1% in 1999.
- The radio was shown to be a significant source of information on family planning for 91% of respondents. Knowledge about the modes of transmission of HIV has declined slightly from 54% in 1995 to 48% in 1999, but the proportion of men stating they are at risk of HIV infection has increased slightly from 42.5% to 44.7% (FPAK 1999).

The findings of the evaluation of the Male Involvement Project show that the initiative of using IEC strategies and providing male family planning clinics has prompted a change in family planning behaviour in the three study districts. The services most sought after by men from the clinics were; family planning services, advice, reading material and treatment/diagnosis of disease (ie: STI).

Table 2: Summary of Initiatives for Reproductive Health Services for Men in Kenya.

Organisation	Information & Education	Outreach	Service	Research
Family Planning Private Sector (FPPS)* * service delivery targeted at private sector.	Provide FP and RH IEC (puppetry, folk media) in male dominated institutions on; male involvement in FP, STI, HIV transmission, condom use, and vasectomy (with FPAK). Develop IEC materials (calendars, videos) and distribute to FP clinics nationally. Behaviour change programmes targeted to men and adolescents on HIV/AIDS risk (arts, drama, music dance, poetry, puppetry, story telling).	Training of service providers on HIV/AIDS syndromic management Conduct workplace schemes in private sector on RH (East Africa Industries, Brit-America Tobacco, Bata, Kenya Ports Authority) Support private sector and NGOs to upgrade workplace schemes with range of FP services. Adolescent RH groups – peer groups in slum areas of Nairobi to inform on STI, HIV/AIDS. CBD of condoms and oral pills (with FPLM). Train trainers on male involvement in FP. Train HIV counsellors (male/female)		

Organisation	Information & Education	Outreach	Service	Research
Ministry of Health	Produce calendars, wallcharts, reference material for use by CBD agents. RH messages on radio. Health information dissemination to Men.	CBD of FP to men including condom, pills, referral, info on STI, infertility, HIV/AIDS. Target adolescents and older men.	National static FP services (men & women) Train male personnel in RH	
Family Planning Association of Kenya (FPAK). * second largest provider of FP after MOH	Multi-media IEC strategy to reach men regarding RH (print, puppetry, radio, TV, folk media, T-shirts, caps, billboards, car stickers, bags, booklets banners, tapes). FPPS runs puppetry aspect. Previously conducted – RH week, <i>Challenge Cup</i> football match promoting RH for men, folk media festivals in workplaces.	Community Health Volunteers (CHV), work in rural areas and workplaces to encourage FP use, partic condoms and refer men to FPAK male clinics. 110 Workplace motivators in 90 manufacturing and agro based industries, provide RH info, counselling, distribute methods.	Male only clinics (Nakuru, Kisumu, Kakamega) for RH and SH. Train service providers in RH provision to include men. Youth Clinics in Eastleigh (Nairobi) and Mombassa. SRH information and services.	<i>Reaching out to Men: the Forgotten Fifty Percent and Male Involvement 'Project'</i> (MIP covers Nakuru, Kisumu, Kakamega). Campaign slogan 'Men who Care'. MIP aim to improve the quality of counselling, attitudes of providers and service delivery environment for men. Activities; a) Establish male-only clinics b) Establish workplace motivator scheme (WPM) c) Developed IEC materials d) Advocacy to encourage men to use condoms and vasectomy (with MOH). Evaluation of MIP – 1995 Baseline and 1999 Evaluation (using h/h survey, WPM test, exit survey, IEC effectiveness questn, FGD, IDI) – MIP <i>Mid-term Evaluation and Reaching out to Men: Case Studies</i>

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
Barclays Bank of Kenya	Provides information to employees on HIV/AIDS transmission and protection. Conduct training sessions to show videos on STI, condom use and HIV/AIDS.		Provide condom vending in washrooms; counselling for infected and non-infected employees in each bank branch; male counsellors for men; financial assistance for medical treatment of STI and HIV/AIDS symptoms. BBK society funds these services. Clinic with GP and nurse	
Population Services International (PSI)	Social marketing initiatives for <i>Trust</i> condoms. Campaign slogans - <i>Let's Talk</i> and <i>Sema Nami</i> ('Talk to Me'). IEC strategies to disseminate HIV/AIDS info – posters, billboards, key rings, wallets, T-shirts, newspaper postings. Music festival to promote Trust and condom use, create awareness of HIV/AIDS. 'Trusted Partner' campaign uses TV, radio, print to promote condom use. Three TV ads – a) Hi I'm Jack b) Forever Mine c) <i>Uki freak bila sox, no diggity ume trip</i> ("Sex without condom, you have fallen")		Provide subsidised <i>Trust</i> condoms.	Evaluation of media campaigns; a) <i>Trust</i> distribution survey b) Mass media surveys of campaigns c) Annual consumer profile survey d) Outlet exit surveys

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
Association for Voluntary Surgical Contraception (AVSC)	Educate men about sexual responsibility. Use mass media to raise men's awareness of RH. IEC includes vasectomy embossed badges, coasters, tattoos (esp for young men).	Train health professionals to counsel men and couples. Men's Challenge Cup (Oct 97 – Jan 98) increase men's awareness of sexual and RH issues. Vihiga Vasectomy Group. Peer health educators on FP to men including vasectomy.	Make condoms available at workplaces and public places. Male clinic (Nairobi) providing sexual and RH, STI, HIV/AIDS, FP (vasectomy), counselling.	Developed COPE (Client Oriented Provider Efficient) strategy for providers of RH to obtain feedback from users. Staff at SDP trained in men's RH. Developed framework to conceptualise men's RH needs and provide list of options for providers when establishing or refining RH services for men. 'Men as Partners' (MAP) Initiative (begun 1996) to bring men into RH matters. Define curriculum for Kenya, training clinical staff, male counselling pre-testing. MAP Workshop 1998 – refine major issues related to men as partners in RH. Review activities and initiatives in Kenya for men's RH under themes: research, communication and service delivery. Develop research agenda, IEC strategies and service delivery strategies.

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
Family Health International (FHI)	Communication strategy through radio and print media. Campaign slogan is <i>Niulize</i> ("Ask me")	IMPACT Project targets men at workplaces for condom distribution and IEC, utilising peer motivation. Sensitise senior management and union leaders. Coverage 45 companies (Western, Nakuru, Mombassa). Recruit and train peer motivators amongst sex workers, community, workplace and youth. Youth outreach through drama and theatre with RH messages.		
International Planned Parenthood Federation Kenya (IPPF)			Supported FPAK with male-only clinics for FP and RH.	Founded CAFS which has conducted research on male involvement in FP.

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
ACE Communications	Developed HIV/AIDS docu-drama.	AIDS intervention campaign (HAPAC) for community leaders, youth groups, schools and beach workers (fishermen, commercial sex workers, small-scale traders) in Nyanza. Show films on HIV/AIDS and use facilitators to initiate discussion. Use peer education by using community leaders (political, religious, educational, family heads) in films.		
Christian Mission Aid	HIV/AIDS awareness in Nyanza province, including seminars on communication, counselling and symptoms.	Visits to schools, churches, men's organisations (football clubs), barazas to advocate behaviour change through music, drama and poems.		
Women Fighting Against AIDS in Kenya (WOFAK)		Outreach teams talk to men at public places about HIV/AIDS. Video shows on real life experiences with AIDS.	Provide voluntary counselling and testing, referral to men's groups, involve men in condom distribution, provide resource centre for condoms and information.	

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
East Africa Industries Clinic		Workplace scheme to create awareness on HIV/AIDS, and provide info on SRH, FP to employees. Train peer educators (by FPPS) and use of IEC materials.	Clinic on site provides condoms, referrals for vasectomy, counselling on HIV/AIDS and info on prevention to employees.	
Family Life Promotion Services (FLPS)		Recruit and train CBD (mostly young men) to work in Eastlands estates of Nairobi, approach male youth in Nairobi and provide info on RH. Show videos, songs, drama, advocacy, on condom use and clinical aspects of vasectomy. Concentration on informal sector.	Provide counselling for men pre and post HIV testing. Provide male contraceptives (condom and vasectomy).	

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
Pathfinder International	Produced film – <i>Yellow Card</i> about rites of passage issues.	Provide male CBD and work-based programmes on RH at sugar plantations. Male CBDs work with leaders of Anglican Church of Kenya to promote use of condoms among men. Community leaders initiative to promote condom use amongst slum dwellers. Peer education at universities (Kenyatta and Egerton) peer outreach, clinic services and FLE course. Produce publication – KU Peer as discussion forum.	Urban RH initiative; - develop IEC - install condom dispensers - distribute condoms through community health care providers.	Research Project: <i>Urban RH Initiative</i>. Improve quality of RH to underserved groups in slums through multi-service provision and counselling, IEC on FP and STI prevention using community based approaches; - assess attitudes to condom use and willingness to sell condoms in communities - availability of community structures to support condom based programmes - assess availability and quality of health services - assess community leaders attitudes to provision of FP, STI/HIV/AIDS info to youth.
Plan International		Train, recruit male community health workers to counsel people in villages on HIV/AIDS, FP and referral (most CHV are women). CBD of male FP methods in home groups – advice and distribution of condoms.	Services for HIV infected and affected people, including condom distribution and awareness campaigns, family rehab, home care for patients, community based HIV counsellors, health education, material support. (normally target women and children)	

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
Nairobi City Council Special Treatment Centre			Regional centre for management of STI. Pre and post-test counselling for STI, HIV, treatment of STI and referral slips for partners, condom distribution, vasectomy advice, infertility screening and treatment.	
Maendelo ya Wanawake (MYWO)		Recruit men as CBDs Train men at <i>Barazas</i> to talk about RH, FGM and HIV/AIDS.		
Kabiro Health Trust	IEC in catchment area. Puppet shows on sexual health, condom use, HIV transmission.	Health talks and videos for youths in school – (drugs, HIV/AIDS, Majuto “Consequences”) 15 CBD (4 male) of male condoms (trained by MOH and FPPS). 25 peer motivators in youth clubs for young male population.	Provide 50 condom dispensers (25 in slums and 25 in hair salons, video houses, pool halls for youth). Provided by Pathfinder.	

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
Christian Health Association of Kenya (CHAK)			RH clinics for men CHAK mission hospitals provide FP methods, STI screening/ treatment, infertility treatment, counselling.	
Marie Stopes		Mobile clinics run through existing govt. clinics.	Provides FP services including those for men (condom, vasectomy), counselling on FP and HIV/AIDS, STI treatment. Male RH clinics (Nairobi)	
Contact Resource Services			Conculty service for providers of RH for men. Offer male counselling, use satisfied clients to market vasectomy, train counsellors to work with male clients, train doctors in motivation for vasectomy.	
APHRC and Population Council				Involving men in FP in Africa. Highlights shortfalls of existing FP initiatives and recommends interventions to increase FP use amongst men.

Table 2: Initiatives in Kenya contd...

Organisation	Information & Education	Outreach	Service	Research
PATH	Develop IEC materials targeted at RH of men and families (posters, FGM, HIV/AIDS).			Fund and implement projects that target RH, eg; Kenya Adolescent RH project (Busia/ Vihiga); Youth one-stop-shop for RH; Youth exchange network for RH.
Department of Community Health, University of Nairobi.				<i>Integrating men into the RH equation.</i> - suggests strategies to increase male participation in RH - identifies barriers to RH services for men.
Population Council				<i>Strengthening the role of men as partners in RH.</i> Lists barriers to male friendly services and the desired components of male-friendly services.
APHRC and FPAK				1. <i>Expanding men's participation in RH in Kenya</i> 2. <i>Enhancing the role of men in FP and RH in Kenya.</i> - identify qualitative characteristics of service delivery model to encourage male use of RH services - Men's knowledge of FP

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APPENDIX A

Organisations visited in Kenya and Malawi.

Kenya

Population Studies & Research Institute University of Nairobi

Department of Sociology, University of Nairobi

Family Planning Private Sector (FPPS)

United Nations Development Programme (UNDP)

International Planned Parenthood Federation Africa Region (IPPF)

National Council for Population and Development

Christian Mission AID (CMA)

Family Life Promotion Services (FLPS)

East African Industries Clinic

Plan International

Innovative Communication Systems (ICS)

Family Planning Logistics Management (FPLM)

Pathfinder International

Association for Voluntary Surgical Contraception (AVSC)International

Population Council, Nairobi

Maendeleo Ya Wanawake Organization (MYWO)

Centre for African Family Studies (CAFA)

Department of Sociology, Egerton University

Division of Primary Health Care

Futures Group Europe

Christian Health Association of Kenya (CHAK)

Family Planning Association of Kenya (FPAK)

Marie Stopes International (MSI)

Barclays Bank of Kenya

Population Services International (PSI)

Nairobi City Council Special Treatment Centre

Women Fighting HIV/AIDS in Kenya

Ace Communications

Family Health International (FHI)

Malawi

Banja La Mtsogolo (BLM)

Care International

Christian Hospital Association of Malawi (CHAM)

Family Planning Association of Malawi (FPAM)

Ministry of Gender, Youth and Community Services

Ministry of Information

Centre for Social Research

Ministry of Health and Population (MOHP)

HOPE

National Association for People Living With AIDS in Malawi (NAPHAM)

Plan International

Population Services International (PSI)

Save the Children USA

Youth Council of Malawi

Adventist Development and Relief Agency (ADRA)

National AIDS Control Programme

UNFPA

USAID

GTZ

UNICEF

DFID

European Delegation