



**Baseline Study: Documenting Knowledge, Attitudes and Behaviours of  
Somali Refugees and the Status of Family Planning Services  
in UNHCR's Operation in Nairobi, Kenya**

August 2011

## ACKNOWLEDGEMENTS

This report was researched and written by Erin McCoy on behalf of Women's Refugee Commission (WRC), and reviewed by Sandra Krause, Jennifer Schlecht, Mihoko Tanabe and Diana Quick of the WRC. This study was a joint effort between the United Nations High Commissioner for Refugees (UNHCR), the WRC and the Centers for Disease Control and Prevention (CDC). Stacy De Jesus (CDC), Nassrin Farzaneh (WRC) and Eva Lathrop (Emory University) provided technical assistance during the planning and implementation of the field research. Nadine Cornier (UNHCR) was responsible for providing overall project direction.

We are grateful to our household survey data collection team and focus group discussion facilitators: Shamsa Abdullahi, Bishara Hassan Mohamed, Zeinab Ismail Madey, Lul Issack Ali, Fardowsa Matan Bulle, Fatuma Dekow Maalim, Fatuma Mohamed Jimale, Fatuma Mohamed Noor, Halima Omar Hussein, Yussuf Mohamed Haji, Adan Abdi Mohamed and Abdi Gedi Ali. This project would not have been possible without the participation of the many Somali refugee women, men and young people in Nairobi, whose insights, time and advice were invaluable.

The WRC is grateful to the UNHCR and their implementing partner GIZ in Nairobi for hosting the mission, assisting with logistics and helping to coordinate interviews, facility assessments and focus group discussions. In particular we would like to thank Mary Kamau and Emmanuel Ojwang of GIZ, and John Burton of UNHCR for their time and tireless assistance. We are also grateful to Dr. Wilbert Shihaji of International Organization for Migration for assistance in establishing a sampling plan, Fatuma Dekow Maalim of GIZ for her interpretation services and community-level support, and Dorina Omondi and Geoffery Marika for their support in conducting facility assessments.

This report is one of a series of five reports documenting baseline findings and recommendations to improve family planning programming for refugees in Djibouti, Jordan, Kenya, Malaysia and Uganda. The reports have similar objectives, literature reviews, methodology and limitations sections. The studies can be found at <http://www.womensrefugeecommission.org/reports>.

Women's Refugee Commission  
122 E. 42<sup>nd</sup> Street  
New York, NY 10168-1289

[info@wrcommission.org](mailto:info@wrcommission.org)  
[www.womensrefugeecommission.org](http://www.womensrefugeecommission.org)

## TABLE OF CONTENTS

Executive Summary.....	5
Key Recommendations .....	5
Introduction .....	8
Objectives .....	9
Literature Review .....	10
Methodology.....	11
Presentation of Findings .....	12
Discussion.....	18
Limitations .....	20
Appendices.....	21
Appendix I: Household Survey Data Tables .....	21
Appendix II: Health Facility Assessment Summary .....	26

## **ACRONYMS AND ABBREVIATIONS**

CPR	Contraceptive prevalence rate
EC	Emergency contraception
FGD	Focus group discussion
FP	Family planning
GBV	Gender-based Violence
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Technical Cooperation)
IUD	Intra-uterine contraceptive device
LAM	Lactational amenorrhea method
MD	Medical Doctor
MOH	Ministry of Health
MPH	Master of Public Health
NGO	Nongovernmental organisation
OCP	Oral contraceptive pill
OJT	On-the-job training
RH	Reproductive health
STI	Sexually transmitted infection
TL	Tubal ligation
WRA	Women of reproductive age (15-49)

## EXECUTIVE SUMMARY

As the result of long-term insecurity and drought in Somalia, it is projected that 516,000 Somali refugees will live in Kenya by the end of 2011. This report explores the knowledge, beliefs, perceptions and practices surrounding family planning (FP) among Somali refugees living in the community of Eastleigh, a suburb of Nairobi where the majority of Nairobi's Somali refugees reside.

The aim of this study was to determine the barriers and challenges at the community and health facility levels that hinder uptake of contraceptives among the Somali refugee community in Eastleigh and the practical ways that the challenges can be addressed. A household survey was conducted in 498 households to gather quantitative data on FP-related knowledge, attitudes and behaviour among women of reproductive age (WRA), 15-49 years old. Eight focus group discussions (FGDs) were conducted with women, men and adolescents in the community to gather further qualitative data on attitudes about and barriers to contraceptive uptake. Facility assessments were conducted in three health centres to examine service availability, quality of services and provider opinions. In addition, four key informants were interviewed using a semi-structured interview guide.

### KEY FINDINGS

The results from the study indicate a contraceptive prevalence rate (CPR) of 6.9% among the population surveyed. Of the total population surveyed, 6.8% currently use modern methods. The most commonly used methods are the pill, injectables and the male condom. Of those who are currently using any FP method, most live with a husband/partner. Unmet need for FP is 9.9%. The most significant barriers to use of FP other than fertility-related reasons were religious prohibition and opposition by husbands. All facilities assessed were found to be acceptable in capacity to provide adequate FP services, though training, capacity building and some improvements to infrastructure were identified as needs. Qualitative data revealed negative attitudes towards the use of contraceptives due to religious and cultural factors favouring large families; a negative stigma relative to those who use contraceptives; misinformation and lack of basic knowledge about reproductive health (RH)/FP; cultural gaps between providers and clients; and low uptake of lactational amenorrhea method (LAM) despite cultural acceptance of breastfeeding.

### KEY RECOMMENDATIONS

The following recommendations are based on the quantitative and qualitative findings of this study:

#### IMMEDIATE RECOMMENDATIONS

FP service delivery at facility level:

1. **Training of providers:** Routine refresher trainings should be provided at the RAISE Training Centre located at the Marie Stopes Eastleigh Nursing Home for all community providers of FP services. Emphasis should be placed on building capacity for comprehensive FP counselling on all methods, with special priority given to:
  - a. Training on provision of accurate LAM counselling to capitalise on cultural acceptance of breastfeeding.
  - b. Building provider capacity for intrauterine contraceptive devices (IUDs).
  - c. The expansion of eligibility for emergency contraception (EC) for cases beyond gender based violence (GBV).

- d. Increasing cultural sensitivity and capacity to understand misconceptions and fears surrounding FP in the community.
2. **Improvement of infrastructure:** Doors should be installed in FP consultation rooms in the city council FP clinic to replace cloth partitions, to allow for privacy and to increase community perceptions of confidentiality. Counselling clients in situations where they cannot be overheard improves communication and increases the likelihood that the method provided is suitable for the client. Other minor improvements should also be made in public facilities to raise community perception of the quality of service provided, such as increased space, permanent signs on consultation rooms, modernisation of waiting and reception areas and electrical light sources in every consultation room.
  3. **Staffing:** Additional nurses should be recruited to work in the city council FP clinic in order to ensure timely FP service delivery by decreasing wait times. Where possible, these providers should be Somali and female. Additional outreach workers and/or interpreters should also be recruited to provide interpretation services for Kenyan staff to ensure culturally sensitive provision of care.
  4. **Education at facility level:** Visual aids, including pamphlets and brochures, should be made available for distribution at health centres, and posters should be placed on walls of health centres for patient education.
  5. **On-the-job training (OJT):** A system modeled on the system employed by Marie Stopes Eastleigh should be developed for providing OJT to all providers of FP services.
  6. **Continuous availability of methods:** UNHCR should work with the Ministry of Health (MOH) to ensure continuous availability of IUDs, implants and injectables in health facilities.
  7. **Referral system:** A system should be developed to ensure that those who receive FP referrals for permanent methods complete the referrals and obtain the desired services.

#### LONG-TERM RECOMMENDATIONS

##### Community sensitisation:

8. **Outreach campaign:** Some of the major challenges affecting FP relate to community beliefs and practices. Social, cultural and religious factors influence the belief that women should have as many children as possible, which negatively affects contraceptive uptake. UNHCR and its community partners should put special effort into targeting and working with community leaders in order to increase knowledge of and improve attitudes toward FP. The campaign should be staffed by well-trained health workers, including community health workers and satisfied users and should aim to:
  - a. Increase knowledge of methods and of RH anatomy and physiology.
  - b. Emphasise the benefits of child spacing for the health of the mother and child, since FP is widely interpreted as limiting the size of one's family, which is considered culturally unacceptable.
9. **Sensitisation of special groups:** Priority should be given to the sensitisation of several important groups:

- a. Religious leaders – There is strong evidence that religious leaders have enormous potential to influence community behaviours. Local religious leaders should be trained in RH and FP, incorporating interpretations of Islamic teachings that encourage responsibility and duty to advocate for good health-seeking behaviours to improve the welfare of the community. Training should emphasise accurate criteria for LAM that differs from breastfeeding.
- b. Men – As primary decision-makers in Somali families, men also play an important role in influencing community acceptance of FP/child spacing services. Education of men should focus on emphasizing the benefits of child spacing for the health of the mother, child and family.
- c. Adolescents – Given the young age at which Somalis commonly marry, it is important to focus sensitisation efforts on young people. Mechanisms should be increased for confidential community-based distribution of condoms.

## INTRODUCTION

Access to FP services is a human right<sup>1</sup> and neglecting FP can have serious health consequences. Restoring access to safe, effective contraceptives can reduce unwanted pregnancies, unsafe abortion and resulting maternal death and disability. It also provides women and girls the autonomy to determine the number and spacing of their children, access to educational and livelihoods opportunities and possibilities for families to manage scarce resources more effectively.

The *Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings*,<sup>2</sup> developed by the Women's Refugee Commission (WRC) on behalf of partners and endorsed by the steering committee<sup>3</sup> of the Inter-agency Working Group (IAWG) on Reproductive Health in Crises in May 2010, outlines existing standards on providing contraceptives from the onset of an emergency and throughout protracted crisis and recovery. It further describes methods of service delivery and recommendations for governments, donors and implementing agencies.

While the United Nations High Commissioner for Refugees (UNHCR) has focused on emergency obstetric care, GBV and HIV/AIDS in the past several years, FP activities have not been given sufficient attention to ensure adequate access for refugees and other persons of concern. FP coverage in camp settings has reportedly been low; programs in the field are often very poor to non-existent. However, in 2010, several country programs reported an increase in uptake of contraceptive methods that could be linked with changes in service provision.

This report explores the knowledge, beliefs, perceptions and practices surrounding FP among Somali refugees living in the community of Eastleigh, a bustling suburb of Nairobi often referred to as "Little Mogadishu," where the majority of Nairobi's Somali refugees live.

When civil war in southern Somalia led to the collapse of the state in 1991, hundreds of thousands of Somali refugees sought safety in Kenya. Large numbers were registered by UNHCR and were sent to camps in 1991 and 1992. The refugee population decreased in the mid to late nineties, when many people returned voluntarily to Somalia or were resettled overseas. The camp population remained relatively stable in the region between 1999 and the late 2000s, before it began to increase again as the result of increased political instability and food insecurity in Somalia.<sup>4</sup> The Shabab Islamist insurgent group, which largely controls southern Somalia, is blamed for causing the current famine in Somalia during one of the country's worst droughts in 60 years. It did so by ousting many aid organisations, causing tens of thousands of people to flee the country.<sup>5</sup> Between January and July 2011 alone, drought and insecurity drove an estimated 96,000 Somalis into Kenya, overwhelming the already overcrowded

---

<sup>1</sup> Under international law, universal access to family planning is a human right. According to Article 16(1) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), all individuals and couples have the "right to decide on the number, spacing and timing of children". The Programme of Action from the 1994 International Conference on Population and Development also notes the right of couples and individuals, "to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so" (Article 7.3). Moreover, General Comment No. 14, para. 12 of the Committee on Economic, Social and Cultural Rights states that the right to the highest attainable standard of health includes the "right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning".

<sup>2</sup> IAWG on RH in Crises, *A statement on family planning for women and girls as a life-saving intervention in humanitarian settings*, May 2010. Accessible from [http://www.iawg.net/IAWG\\_%20FP%20Statement\\_Final.pdf](http://www.iawg.net/IAWG_%20FP%20Statement_Final.pdf).

<sup>3</sup> IAWG on RH in Crises Steering Committee agencies include American Refugee Committee, CARE International, Centers for Disease Control; Columbia University School of Public Health, International Medical Corp, International Rescue Committee, Jhpiego, JSI Research and Training Institute, Marie Stopes International, UN High Commissioner for Refugees, UN Population Fund; Women's Refugee Commission, World Health Organisation.

<sup>4</sup> A. Lindley, "Protracted Displacement and Remittances: The View from Eastleigh, Nairobi," (2007).

<sup>5</sup> Jeffrey Gettleman, "Misery Follows as Somalis Try to Flee Hunger," *New York Times*, 15 July 2011.



Dadaab refugee complex, the largest camp complex in the world.<sup>6</sup> Camps designed almost two decades ago to accommodate a total of 90,000 people now host more than three times that number.

While the majority of Somali refugees and asylum-seekers in Kenya live in designated camps, they often seek to make their way to urban areas to escape the harsh living conditions of camps and search for better opportunities, especially given the protracted nature of the conflict in Somalia.<sup>7</sup> It is projected that there will be 516,000 Somali refugees in Kenya by December 2011.<sup>8</sup> Given the intensity of the recent influx, the political will to deal with protracted displacement now risks being overwhelmed by the emergency response needed to deal with recent arrivals.<sup>9</sup>

The presence of urban refugees is not unique to Kenya; more than half of the world's refugees now reside in non-camp settings.<sup>10</sup> However, the actual number of refugees, IDPs, returnees and stateless persons in any urban area is extremely difficult to ascertain. The precise population of Eastleigh is unknown, but estimates range from 200,000 to 500,000.<sup>11</sup> Unlike the hundreds of thousands of refugees living in Kenya's camps, refugees residing in urban areas constitute a largely invisible population; little is known about their numbers, profile, status, location and livelihoods.<sup>12</sup> For these reasons, targeting the urban refugee population in Nairobi is a major challenge. This difficulty is further compounded since Nairobi's refugees are often reluctant to come forward for support due to fear that they could be deported or sent to refugee camps, making service provision especially challenging.<sup>13</sup>

## OBJECTIVES

### *Goals*

The goals of this baseline study were to document knowledge, beliefs, perceptions and practices of refugees, as well as the state of service provision in the select UNHCR operation to improve programming and subsequently increase uptake of FP services among women, men and adolescents.

### *Objectives*

- To increase baseline information to guide policy and planning.
- To improve quality of services through training and guiding health and community providers, and improving infrastructure as required.
- To adapt programmes according to barriers, beliefs, fears and perceptions in terms of information, education and communication efforts and service delivery.
- To expand access through a broader choice of contraceptive methods, community-based distribution and linkages with national programmes or other in-country initiatives as appropriate.

---

<sup>6</sup> UNHCR, *UNHCR Issues Revised Appeal of US\$145 Million for Horn of Africa Emergency*, 2011, Available: <http://www.unhcr.org/4e31562a6.html>.

<sup>7</sup> UNHCR, 2011 *UNHCR Country Operations Profile - Kenya*, 2011, Available: <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e483a16>.

<sup>8</sup> UNHCR, 2011 *UNHCR Country Operations Profile - Kenya*.

<sup>9</sup> Lindley, "Protracted Displacement and Remittances: The View from Eastleigh, Nairobi."

<sup>10</sup> Paul Spiegel and Public Health and HIV Section at UNHCR, "Urban Refugee Health: Meeting the Challenges," *Forced Migration Review* 34 (2010).

<sup>11</sup> Lindley, "Protracted Displacement and Remittances: The View from Eastleigh, Nairobi."

<sup>12</sup> S. Pavanello, S. Elhawary and S. Pantuliano, "Hidden and Exposed: Urban Refugees in Nairobi, Kenya," (2010).

<sup>13</sup> Zetter, R. and Deikun, G. "Meeting Humanitarian Challenges in Urban Areas," *Forced Migration Review* 34 (2010).

### *Study Question*

This study aimed to answer the primary question: What are the barriers and challenges at the community and health facility levels that hinder increased uptake of contraceptives among the select refugee communities, and what are the practical ways that the challenges can be addressed?

## **LITERATURE REVIEW**

According to current indicators, the level of use of modern contraceptives in Somalia is dramatically lower than modern contraceptive use in Kenya. While very few RH indicators are available for Somalia, a World Health Organisation (WHO) survey in 2006 reported that 1.2% of currently married women were using modern contraceptives, with slightly higher use reported among women living in urban areas.<sup>14</sup> The Kenya Demographic and Health Survey (KDHS) 2008-09 reported a CPR of 32.0% among all WRA and 55% among currently married WRA living in Nairobi.<sup>15</sup>

Several qualitative assessments of knowledge, attitudes and behaviour on FP among Somali refugee populations in camp settings indicate low uptake of contraceptive methods as well as widespread negative attitudes and hostility toward FP/child spacing. FP services are perceived as prohibited by Islam, and large families are favoured. The total fertility rate among the Somali population is between 5.7 and 6.7, irrespective of their geographical location.<sup>16</sup> Estimated CPR is cited as around 1%.<sup>17</sup> However, very limited quantitative information exists on use of contraceptives among Somali refugees residing in urban settings.

Kenya has a strong commitment towards RH that includes a Division of Reproductive Health within the MOH. The MOH provides comprehensive RH policies, guidelines and strategic plans to meet the RH needs of men, women and young people, including Family Planning Guidelines for Service Providers (last revised March 2005). The Kenya Service Provision Assessment of 2010 reports that 85% of Kenyan health facilities offer some type of temporary modern methods of FP at minimum, with little difference in the availability of services by type of facility.<sup>18, 19</sup> FP services are widely available in Eastleigh health centres and hospitals.

---

<sup>14</sup> "Republic of Somalia Country Profile," 2006. Available from [http://www.who.int/making\\_pregnancy\\_safer/countries/som.pdf](http://www.who.int/making_pregnancy_safer/countries/som.pdf).

<sup>15</sup> *Kenya Demographic and Health Survey 2008-09* (Nairobi: Kenya National Bureau of Statistics, 2010).

<sup>16</sup> UNHCR Dadaab Sub-Office, *Report on the Status of Safe Motherhood and Child Spacing Services in Dadaab Refugee Camp: An Assessment of the Health System and the Somali Community's Knowledge, Attitude, and Perception* (Nairobi: 2010).

<sup>17</sup> *Ibid.*

<sup>18</sup> Facility provides, prescribes or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, IUDs, male condoms or female condoms.

<sup>19</sup> *Kenya Service Provision Assessment Survey 2010* (Nairobi: Ministry of Medical Services and Ministry of Public Health and Sanitation, 2011).

## METHODOLOGY

The baseline study methodology consisted of a household survey, facility assessments, in-depth interviews and FGDs.

The study community was located in Eastleigh, a predominantly Somali community with a total estimated population of 200,000 to 500,000 inhabitants. Residents of Eastleigh include Kenyans, refugees from Somalia and an indigenous Somali-Kenyan population, as well as refugees from other central and east African countries. FGD participants and household survey respondents were Somalis and indigenous Kenyan-born Somalis. Kenyan-born Somalis were included since the host community of Eastleigh has access to the same resources as the refugee community and their health-seeking behaviours are similar.

Participants in all four methods were informed of the purpose, process, potential risks, use of the information, the team's commitment to confidentiality, and their right to refuse to participate, to leave or to remain silent at any time.

All data were analysed by triangulation and verification of findings with other available information.

### *Household Survey Methodology*

A household survey was conducted between June and July 2011 using the adapted CDC RH assessment toolkit. The survey was used to gather quantitative data on FP-related knowledge, attitudes and behaviour among WRA.

To select respondents, all 1,248 plots in the community were assigned numbers from which 500 numbers were selected at random. Each block in Eastleigh is divided into plots, which consist of anywhere from one household to as many as an estimated 50 households. Since organisation of the households did not permit an organised division, interviewers approached each selected plot and asked to be directed by the gatekeeper to the nearest Somali household. Using a chart, interviewers randomly selected one woman from all WRA in the selected household. If the selected WRA was not home at the time of the first visit, up to seven contacts were attempted before she was classified as absent.

After the woman gave oral informed consent, pre-tested and piloted structured questionnaires were administered in the Somali language by trained community data collectors at the home of the respondent, in privacy where possible. The instrument included questions on respondents' background characteristics, current and previous pregnancies, knowledge and use of FP, and marriage and live-in partnerships. Questions were asked verbatim and rephrased only if a respondent did not understand. Each interview lasted approximately 30 minutes. Where possible, a printed summary of information about the survey and contact details for a German Technical Cooperation (GIZ) staff member who could provide more information on FP services were provided to each participant in the Somali language. All interviewers were recruited from the host community and were female. Review, cleaning and data entry of the completed questionnaires took place in the field by the supervisor during the study period. The total number of respondents was 442, a response rate of 89%. Data entry and analysis were performed using CSPro and SAS software.

### *Facility Assessment Methodology*

Facility assessments were conducted to examine service availability, quality of services and provider opinions. Three facilities were selected for assessment by GIZ and UNHCR staff based on the facility's provision of services to the Eastleigh refugee community.

After gaining informed consent in written form at each facility, an assessment was administered that included interviews of a provider as well as a staff member in charge about their perceptions of the facility's capacity to provide FP services. The assessment also included an observation checklist. Interviews were administered in English and were conducted by the supervisor, local Medical Doctor (MD)/Master of Public Health (MPH) candidates and a Somali community member.

### *In-depth Interview Methodology*

Four in-depth interviews with key informants were used to learn about challenges and barriers to increasing contraceptive uptake within the refugee community. Respondents were selected using purposeful sampling by GIZ staff and the supervisor. They included three refugee leaders and one Somali Kenyan host community member.

After giving written informed consent, each respondent was asked a set of pre-structured questions. Two interviews were conducted in Somali with the assistance of an interpreter and two were conducted in English.

### *Focus Group Discussion Methodology*

FGDs were held with women, men, adolescent girls and adolescent boys to gather further qualitative data on attitudes and barriers to contraceptive uptake. Purposeful sampling was used to select participants, with the help of several community members. Explicit considerations were made to ensure that a variety of community members were included. Six FGDs were convened in Eastleigh, consisting of two groups of men age 22 and above, one group of men age 16 to 22, two groups of women age 22 and above and one group of women age 16 to 22. The total number of participants was 41. The majority of participants were refugees, while several participants were Kenyan-born Somali members of the community. Some discussions were conducted only in Somali, others in a mixture of Kiswahili, English and Somali, one in Gurreh and another in both Gurreh and Somali. Facilitators later translated the discussions from audio recordings of the sessions, which the supervisor then transcribed. Oral consent was obtained for both participation and permission to make an audio recording of the discussion.

### *Ethical Considerations*

The study received ethical clearance from UNHCR -Geneva. Each data collector underwent training in study ethics adapted from the Family Health International curriculum.<sup>20</sup> No identifying characteristics of respondents were recorded during data collection except for those who gave consent, and audio recordings of FGDs were destroyed after transcription.

## **PRESENTATION OF FINDINGS**

### *Household Survey*

*Knowledge of Contraception.* Knowledge of FP among the women interviewed was low. Among all women, the most widely known methods of FP included the male condom, with 47.5% of all women

---

<sup>20</sup> Family Health International. (2011). Research Ethics Training Curricula. From <http://www.fhi.org/en/RH/Training/trainmat/ethicscurr/index.htm>.

reporting that they had heard of it; 39.3% of women interviewed had heard of injectables; 33.9% had heard of oral contraceptive pills (OCPs); and 22.6% had heard of the female condom. Withdrawal, implants, rhythm/calendar/counting days, the IUD, EC and tubal ligation (TL) were known by fewer than 20% of the women interviewed; TL was the least-known method. The proportion of women who had been instructed on how to use the methods was even lower. The results for awareness of methods and instruction on their use is shown in Table 1.

*Use of Contraception.* The proportion of women who reported having ever used any FP method was 27.4% among all women interviewed. The proportion of women currently using any FP method was 6.9%. The proportion of women currently using a modern FP method was 6.8%. Of those who reported using a method, almost all reported using a modern method; of 39 users, only one woman reported using a traditional method. OCPs were by far the most commonly used method, used by 41.9% of women who reported currently using any method. Injectables were the second most commonly used, at 29.0% of current users. No HIS data exist for CPR for Nairobi to compare to these findings, since total population is unknown. The results for use of contraception are shown in Tables 2 and 3.

*Differentials in Contraception Use.* Among those who reported currently using a method, 43.0% were aged 15 to 24, 27.9% were 25 to 34, and 29.1% were 35 to 49. Among women who reported current use of a method, 79.8% were currently living with a husband or partner and 20.2% were not living with a husband or partner. The majority of current users had no prior pregnancies. Table 4 shows the results of demographic characteristics of women currently using a FP method.

*Source of Modern Methods.* Among women who reported current use of a modern FP method, 44.0% last obtained it from a hospital, 23.8% from a health centre in the community, 17.9% from a pharmacy, and 13.1% from a supermarket/market. Table 5 shows the distribution of locations where the method was reported to have been last obtained. Table 6 shows the distribution of locations where women who reported having heard of a specific method said they would go to get the method.

*Barriers to FP.* Unmet need for FP is defined here as the proportion of women at risk for pregnancy who want to space their next birth or stop childbearing entirely but are not using contraception. Findings reveal 9.9% of married women have an unmet need for FP. Among women who reported ever having heard of a method, the most common response to what they believed was the main problem with using the specific method was “I don’t know.” The second most common response reported was “no problem,” and the third most common reason cited was related to opposition to use. The least common responses had to do with lack of access. Among women currently living with a husband or partner but not currently using a method, the most common reasons mentioned for not using a method, excluding fertility-related reasons, were religious prohibition (25.9%) and opposition by husband (20.6%). Results of findings related to barriers to FP are shown in tables 7, 8, and 9.

*Intention to Use a Method.* The proportion of women not currently using a FP method but reporting that they were planning to use a method in the next 12 months was 6.3%. Table 10 shows the results of intent to use.

#### *Health Facility Assessments*

An acceptable method mix was available in stock at the time of assessment at each of the facilities, including male condoms, female condoms, combined oral contraceptives, progestogen-only oral contraceptives, injectables, EC, IUDs, implants and information about LAM. All three facilities were able to provide temporary, long-term and permanent methods, with the exception of one facility, which does

not perform vasectomies or TL, but does offer referrals for these services. Staff reported some problems in obtaining IUDs, implants and injectables, methods which facilities cited as frequently problematic to obtain due to government stock-outs.

Functioning referral systems existed in all three facilities to ensure that all client visits, including post-delivery, post-abortion, sexually transmitted infections (STIs) and visits with adolescents included an FP assessment and referral as appropriate and also to address staff capacity/limitations for method provision. However, there was no system in place in two of the facilities for verifying that referred clients actually obtain the services for which they are referred.

Of the three facilities visited in Eastleigh, all had adequate staff to provide FP methods. In the private facilities assessed, at least one staff person was available to provide FP services throughout the evenings and on weekends. Although the public FP clinic assessed does not operate on evenings and weekends, long-term methods are accessible at those times since the maternity unit is operational at all times.

All staff from the Marie Stopes Eastleigh facility undergo FP training every year in the RAISE Training Centre located at the Marie Stopes Eastleigh Nursing Home. The RAISE centre also hosts trainings for maternal and child health workers from all over the continent as part of the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative. Marie Stopes staff also receives regular on-the-job training (OJT) in FP. Of the two other facilities assessed, one had not had FP training for more than two staff in the past two years nor does it provide OJT, while in the other facility approximately half of the nurse-midwives were provided training by JHPIEGO in the past two years. However, the latter facility does not provide OJT. While the providers that were interviewed in all facilities reported feeling mostly confident in their ability to provide comprehensive FP services to clients, they all expressed the desire and need for more continuous FP training.

Staff at all facilities reported that they provide counselling on LAM and natural methods to clients but reported feeling hesitant to encourage it since it is not as effective as the other methods. They also reported a negative attitude towards FP in the community, and attributed low FP uptake to religious belief in addition to rumours and misconceptions about the side effects and long-term ramifications of the use of FP on a woman's fertility.

All three facilities received acceptable scores of quality measures and capacity to meet infection prevention standards. Facilities were located in fairly safe areas and the clinic environments were acceptably clean. At the two private facilities, waiting times were perceived by staff and clients as acceptable and the infrastructure considered adequate. However, at the public facility, clients reported dissatisfaction with waiting times, a sentiment echoed by staff who reported often being backed up, especially in the mornings. Consultation rooms in the public clinic had curtains to give a sense of privacy, providing visual but not auditory privacy. During observation of a consultation in the public facility, no reassurance of confidentiality was verbally offered by the provider. None of the three facilities had any printed educational material available for clients to take home.

All three facilities reported that they have extremely low use of services among unmarried adolescents, a fact that they attributed to cultural stigma as well as a low level of sexual activity among unmarried people in the population. A summary of findings from the facility assessments is shown in Table 11.

*Good Practice:* On days when training of providers of the Marie Stopes Eastleigh facility take place, the clinic offers free FP services and reports high utilisation of services on these special FP clinic days. Two

outreach teams also provide mobile outreach services in the community and provide all methods, including TL and vasectomy at these locations.

### *Focus Group Discussions*

Among the eight FGDs, there was wide variation in belief about how old a woman should be when she gives birth to her first child, though general consensus was reached in both adult male and female groups that a woman is expected to become pregnant as soon as she marries. Adult male groups agreed that this could ideally be as young as nine years old if economic circumstances allow and gave religious justification for marriage between ages nine and 12. Adult females generally agreed that most women in the community marry at about 17 or 18 years of age.

There was agreement between adult male and female groups that having as many children as possible is favoured as long as the woman is healthy and strong. One adult man said, “The status of the family is best if the number is high.”<sup>21</sup> There was broad agreement among participants there is no limit to the number of children a woman should have. Female participants strongly agreed that God’s will determines the number of children a woman should have, but did not readily offer specifics: “Any number that God can give.”<sup>22</sup> Male groups elaborated on reasons for having as many children as possible, often citing 12 to 14 as an admirable range, made possible if a girl marries early. While some personal agency was acknowledged in the decision-making process, one man added that as Somalis, “We are Nomadic, so we should have representatives. Therefore, in terms of numbers, we should have as many as possible, [which could be] 10, 100; it all depends on what God decides and whatever number he tries to bless...A man boasts to his friends by telling them he has many children.”<sup>23</sup>

Nearly all respondents in FGDs had heard of FP. However, attitudes towards using modern methods were extremely negative except in situations where a woman has health problems. “If the girl is seen with these things, she will be ashamed of herself,”<sup>24</sup> said one man.

Nearly all participants said they believed that very few people in the community use FP methods. Male groups referred to FP methods as things that come from outside [western] cultures, and expressed a deep mistrust of them due to their grave side effects, including high blood pressure, weight gain, cancer, infertility and death. “If you decide to use FP,” said one man, “the society will abuse you, you will be stigmatized and they will tell you that you are adopting another culture instead of your own.”<sup>25</sup> Another sentiment frequently echoed was that to use FP is to interfere with and even wage war against divine will. As one woman remarked, “If you are using a method, you are fighting with God’s creation.”<sup>26</sup> Several adult women’s FGDs discussed incidents they had heard of in which a woman used a method and God allowed her to become pregnant outside of her uterus.

Most participants, both adults and adolescents, agreed that Islam does not allow use of the child spacing methods, frequently referred to as “drugs” or “chemicals,” and consider their use a sin that is likely to invoke the wrath of God and even cause harm to a woman’s body. The only exception mentioned was breastfeeding, which respondents said is mentioned in the Koran as an acceptable method to be used for two years after the birth of each child. Although breastfeeding was the most frequently mentioned

---

<sup>21</sup> Focus group discussion with adult men, Nairobi, Kenya, 14 July 2011.

<sup>22</sup> Focus group discussion with adult women, Nairobi, Kenya, 12 July 2011.

<sup>23</sup> Focus group discussion with adult men, Nairobi, Kenya, 14 July 2011.

<sup>24</sup> Focus group discussion with adult men, Nairobi, Kenya, 15 July 2011.

<sup>25</sup> Focus group discussion with adult men, Nairobi, Kenya, 14 July 2011.

<sup>26</sup> Focus group discussion with adult women, Nairobi, Kenya, 12 July 2011.

method by adult female groups, women were able to name most other methods as well. Though less frequently mentioned than breastfeeding, withdrawal was also noted as an acceptable method according to Islam. Male groups were less familiar with specific methods than female groups. Negative attitudes toward modern methods permeated the entire discussion in each group, although negativity was strongest amongst males and more variation of opinion was expressed in the adult female groups.

The majority of respondents indicated that while most couples do not discuss FP, the man is the primary decision-maker on most matters, including RH matters. In relationships where the couple does discuss child spacing, ultimately since Islam dictates that men have the final say, men will decide whether or not a couple practises FP. Several participants mentioned that extended family members also participate in decision-making regarding use of FP.

Respondents named several health and welfare benefits of child spacing, though most participants reiterated their belief that FP is not beneficial. Benefits mentioned included allowing the mother to rest and regain strength, allowing the child to grow well, and being able to provide for the family economically and by being able to feed the family well. Some participants acknowledged the economic limitations of living in an urban setting and the subsequent difficulty of providing for a large family. Both adolescent male and female respondents said that using FP prevents HIV/AIDS and other STIs as well as a way to prevent pregnancy. "I [would tell you] not to have sex because there are diseases like AIDS,"<sup>27</sup> said one female. However, they also recognized that using FP methods itself brings shame to the family in the eyes of the community: "A lot of things depend on the community, like if a girl uses FP methods for child spacing or even avoiding pregnancy, people are going to start saying, 'The daughter of so and so is using those methods.' This will bring shame to the family and even the girl."<sup>28</sup> Female adolescents acknowledged that spacing children is beneficial to the mother.

Other respondents expressed the belief that the more children he or she has, the better off the family will be economically since the children can provide for each other and for their parents. One adult man said: "If you have more children, you are stronger, like an army. If you have more kids, you have more wealth, and the kids will protect your wealth."<sup>29</sup> The belief that God provides for every child was recurrent. "God provides for each and everyone. It does not depend on if you space or not,"<sup>30</sup> said one woman.

A general consensus was voiced in adult male groups that due to education and lifestyle changes experienced in migration to city life, FP is more commonly used by Somalis in Nairobi than in Somalia: "If you consider the bush areas, you can have as many children as you want so they can look after your camels. If you look at the cities, those who have many children are only those who have wealth."<sup>31</sup>

Adult respondents indicated a preference for private health facilities over public ones, expressing that they believed they were cleaner and the doctors were more qualified than at the public facilities. Adolescents said that they believed information about contraceptives is available from the UN, government hospitals, health centres, dispensaries and at the city centre. Adults said that FP services were free in some places but that costs vary widely in others, while adolescents said that all services and methods were available only for a fee.

---

<sup>27</sup> Focus group discussion with adolescent females, Nairobi, Kenya, 13 July 2011.

<sup>28</sup> Focus group discussion with adult men, Nairobi, Kenya, 18 July 2011.

<sup>29</sup> Focus group discussion with adult men, Nairobi, Kenya, 14 July, 2011.

<sup>30</sup> Focus group discussion with adult women, Nairobi, Kenya, 13 July 2011.

<sup>31</sup> Focus group discussion with adult men, Nairobi, Kenya, 19 July 2011.



When asked what problems or challenges community members experience in getting FP services, several men's groups discussed instances in which they heard of women being misled by providers. "They went to get an injection for six months, and instead they get it for five years,"<sup>32</sup> said one man. Several adult male groups also mentioned long queues, aggressive staff and language barriers. "We don't understand the language, and we quarrel and argue [with the staff],"<sup>33</sup> one man said. Groups of adult women did not name specific challenges other than general disobedience to God leading to infertility, but others asserted that "if you use it the correct way, the way the doctor says, there will be no complications."<sup>34</sup>

Many FGD participants articulated the belief that no one could promote FP since the culture and religion are opposed to it. However, some adult female groups agreed that satisfied users could help promote FP and sensitise others. Several adult males said that they believed it was good to seek advice from a sheikh in the community. Other respondents mentioned they believed that nongovernmental organisations (NGOs), health workers and providers of services were most qualified to help promote them in the community through outreach campaigns. "If the doctors tell their patients, that is how the information will reach the community,"<sup>35</sup> said one woman. Adolescent males said that they believed media campaigns would be effective.

Most participants in adolescent groups said that they seek advice from a doctor at clinics or hospitals when they have a health problem, although some stated that they prefer to go straight to a pharmacy. The common view expressed was that the majority of young people do not become sexually active until they marry and that those who do have sex are "undisciplined and uncultured" since it is against the teachings of Islam. None of the female adolescent respondents were able to name any methods and the male adolescents mentioned the male condom as well as the use of panadol (paracetamol - a pain killer) as a form of contraception. They said that they would obtain contraceptives from health centres, vending machines, dispensaries and other shops should they want them.

### *In-depth Interviews*

Respondents said that according to Islam, a girl can get married as young as nine years old if she is healthy enough, but said that it is more common in the community to marry between ages 15 and 18: "In Kenya, girls get married later. Most girls have come to Kenya with their families, and most families here do not accept marriage unless they are very selfish...or unless they have no knowledge."<sup>36</sup> It is expected that she will begin having children as soon as she is married.

Respondents also articulated the community's expectation that a woman is to have as many children as possible and that a family's financial situation is not a factor in determining how many children a family will have: "Every child comes with his own food and budget from Allah."<sup>37</sup> One refugee leader also expressed the belief of the community that having many children is advantageous since some may die, a common view which also emerged in FGDs. Respondents expressed the belief that if a woman in Eastleigh is not giving birth to many children, the community will pressure the husband to divorce her: "You are a bad omen in the community when you do not give your husband children."<sup>38</sup>

---

<sup>32</sup> Focus group discussion with adult men, Nairobi, Kenya, 14 July 2011.

<sup>33</sup> Focus group discussion with adult men, Nairobi, Kenya, 19 July 2011.

<sup>34</sup> Focus group discussion with adult women, Nairobi, Kenya, 12 July 2011.

<sup>35</sup> Ibid.

<sup>36</sup> Interview with male refugee leader, Eastleigh, Nairobi, Kenya, 17 June 2011.

<sup>37</sup> Ibid.

<sup>38</sup> Interview with female refugee leader, Eastleigh, Nairobi, Kenya, 17 June 2011.

Each respondent agreed that spacing births is important both because it is mandated by Islamic law and because it is good for the health of the mother. None of the respondents were able to name specific methods of FP, with the exception of injections and “Breastfeeding for two years,” which they said is taught in the Koran. They agreed that two years is a good amount of time to space births. There was general consensus among respondents that the community’s attitude toward FP is different in Kenya than it was in Somalia; in Kenya there is less stigma associated with using FP, women are likely to have fewer children and women are more likely to begin having children at an older age.

When questioned about FP services in the community, two respondents mentioned that people prefer to go to private clinics because of long queues and unsatisfactory conditions in the public facilities: “I wouldn’t go to the public clinic because there are a lot of people there... The place where the people are sitting is very small, and the air smells bad because there are lots of people sitting in the waiting area inside. The best ones look smart, clean, and the doctors and nurses are friendly.”<sup>39</sup> Furthermore, Somali individuals are often subject to mistreatment and discrimination, elaborated the respondent: “Somalis in Kenya are treated like second-class citizens. When you go to the hospital, they are not nice. The doctors and nurses should be friendly to the Somali people...These people they do not know how to talk to somebody. They make the Somali people to feel very low.”<sup>40</sup>

In-depth interview respondents emphasised the need for awareness among the community and recommended that community organisations and religious leaders work together to sensitise women, men and youth in outreach campaigns and in clinic waiting rooms.

## DISCUSSION

Findings indicate a CPR nearly seven times greater than that documented in previous studies of Somalis in other geographic locations. The data suggest a greater openness to the use of FP by the urban Somali population than has been found in other settings where Somalis reside.

One major theme that emerged from the findings is the integral role of religion in the community, which cannot be understated as it relates to attitudes toward RH and FP. The use of modern methods is widely interpreted as prohibited by Islam and large families are culturally favoured, posing a major challenge to the uptake of FP services. Moreover, a common belief in the community is that the number of children that a woman has is determined according to God’s will. Many women reported both religious and partner opposition to the use of FP and said that they believe it is necessary for a woman to hide her use of FP as a way to deal with community and familial disapproval. Islamic belief is that once a child has been created, he or she will be taken care of by God and even “comes with his own food and budget from Allah,”<sup>41</sup> suggesting that FP promotion should be approached by emphasising the benefits of FP on the health of the mother and child, rather than on the economic benefits of child spacing. Sensitisation of the community through this approach should be especially stressed among community religious leaders and men.

Another theme that emerged from the findings is the existence of widespread misconceptions that modern methods cause infertility and significant side effects that threaten health. While findings from FGDs indicated that most people have very basic knowledge of the existence of FP methods, triangulation

---

<sup>39</sup> Interview with female Somali Kenyan community member, Eastleigh, Nairobi, Kenya, 8 July 2011.

<sup>40</sup> Ibid.

<sup>41</sup> Interview with male refugee leader, Eastleigh, Nairobi, Kenya, 17 June 2011.

of data from the household survey suggests that few women have been instructed in how to use the methods and that very few women know enough to form an opinion about the main problem with a specific method. When FGD participants voiced misinformation about FP during discussions, the misinformation was not challenged by other participants. These misconceptions suggest a low level of knowledge regarding RH and basic anatomy and physiology, which is likely exacerbated by the threat of stigma that discourages open discussion of such matters.

The findings from the study also indicated concerns about confidentiality and a high level of mistrust between providers and clients. Women and men reported often “quarrelling” with providers and noted language differences as a barrier to communication. They reported a perceived lack of respect on the part of providers and a general resignation to their low status in society, suggesting that opportunity exists for growth in provider cultural sensitivity. However, lack of access did not emerge from the findings as a significant barrier to uptake of FP services and most WRA from the survey and in FGDs were able to easily identify a location where FP methods can be obtained in the community.

Triangulation of data indicates an important opportunity for emphasis on LAM and natural methods. This is highlighted by the community’s cultural and religious acceptance of “Breastfeeding for two years between children,” which many people cited as the only method acceptable according to Islamic law. Withdrawal was also mentioned as a religiously acceptable method to space births, though less frequently than Breastfeeding. Despite cultural acceptability of breastfeeding and withdrawal, interviews during facility assessments revealed a hesitance on the part of providers to place much emphasis on LAM and natural methods due to their perceived low level of success when compared with other methods. The community’s acceptance of breastfeeding and withdrawal as viable methods for child spacing presents strong opportunities for emphasis on LAM as a FP method, although accurate criteria should be presented, as it differs from breastfeeding.

This study of FP in the urban refugee setting of Eastleigh, Nairobi, Kenya is a preliminary one, but its findings suggest that there is much to be done to reduce the barriers and challenges at the community and health facility-levels that hinder increased uptake of contraceptives among the Somali refugee community. Although the humanitarian crisis in Dadaab frequently makes headlines today, the reality of daily life for refugees living in Nairobi is less documented. This study highlights the need for deepened commitment to the FP needs of Somali refugees living in Nairobi in order to ensure that practical challenges are adequately addressed.

## LIMITATIONS

The most significant limitation for the household survey portion of the study was the self-reported nature of the information. FP is a highly sensitive and culturally taboo topic in the Somali community, so findings from the survey regarding knowledge and use of contraceptives are likely lower than in reality, especially among younger and/or unmarried respondents. Results were also potentially affected by the difficulty of finding a private space to conduct the interview in some households. Possible reporting bias was minimised through interviewer training and questionnaire piloting. Due to cultural taboos, results from the question “Have you had sexual intercourse in the past 30 days?” were deemed too tenuous to produce reliable information on barriers to FP among women who are at risk for pregnancy. Instead, marital status was used to determine unmet need.

Another limitation of the survey was lack of household population information, which affected the representativeness of the sample. Spatial sampling methodology, used in this survey, over-represents certain socio-economic groups in some settings. A clear understanding of the number of households in each plot may have strengthened the study’s ability to provide more representative data through weighting the data obtained. In addition, one data collector reported basing selection of the household on each selected plot on where the gatekeeper told her was a household with many women, a method which led to the exclusion of certain households. Moreover, some areas of the community were excluded from selection for security reasons, also possibly contributing to non-representative sampling.

Limitations for FGDs included non-representative sampling, translation error and possible inconsistencies arising from the presence of multiple translators and limited number of sessions resulting in potential lack of saturation on some topics. Moreover, it was discovered that other NGOs offered compensation for participation in FGDs for previous studies, which may have further affected representation since compensation was not offered for FGDs in this study.

Limitations for in-depth interviews included non-representative sampling and translation error.

Limitations for facility assessments included time constraints, which meant that FP consults were not observed in two of three facilities.

## APPENDICES

### APPENDIX I: HOUSEHOLD SURVEY DATA TABLES

<b>Method</b>	<b>Awareness of method % (n) women</b>	<b>Instructed how to use method % (n) women</b>
Pill	33.9% (149)	24.7% (111)
IUD	5.4% (25)	4.4% (20)
Male condom	47.5% (205)	21.8% (96)
Female condom	22.6% (98)	5.0% (21)
Implants	16.8% (78)	9.3% (47)
Injectables	39.3% (172)	21.5% (92)
Emergency contraception	4.6% (21)	3.9% (18)
Tubal ligation	1.7% (10)	1.4% (6)
Rhythm/calendar/counting days	7.1% (36)	4.4% (22)
Withdrawal	16.9% (71)	14.5% (58)
Other	2.0% (9)	2.0% (9)

*\*Percentages may add up to more than 100% as respondent may give more than one response.*

<b>Indicator</b>	<b>% (n) women</b>
Proportion of women who have ever used any family planning method	27.4% (119)
Proportion of women who are currently using a <u>modern</u> * family planning method (Contraceptive prevalence – modern methods)**	6.8% (36)
Proportion of women who are currently using <u>any</u> family planning method (Contraceptive prevalence – any methods)**	6.9% (37)

*\*Modern family planning methods include the pill, IUD, male and female condoms, implants, injectables, emergency hormonal contraception, tubal ligation and vasectomy.*

*\*\*The denominator may include women who are not at risk for pregnancy because they are currently pregnant, in fecund, or have had a hysterectomy.*

**TABLE 3: FAMILY PLANNING METHOD BEING USED AMONG WOMEN WHO ARE CURRENTLY USING ANY FAMILY PLANNING METHOD, NAIROBI 2011 (N = 39)**

Method	% (n) women
Pill	41.9% (14)
Injectables	29.0% (10)
Male condom	24.7% (8)
Implants	18.3% (10)
Emergency contraception	4.3% (1)
Lactation amenorrhea	2.2% (1)
Withdrawal	2.2% (1)
Tubal ligation	1.1% (1)
Female condom	0.0% (0)
IUD	0.0% (0)
Periodic abstinence	0.0% (0)
Rhythm/calendar/counting days	0.0% (0)
Vasectomy	0.0% (0)
Periodic abstinence	0.0% (0)
Other	0.0% (0)

**TABLE 4: DEMOGRAPHIC CHARACTERISTICS OF WOMEN WHO ARE CURRENTLY USING ANY FAMILY PLANNING METHOD, NAIROBI 2011 (N = 39)**

Characteristic	% (n) women
<b>Age</b>	
15-24	43.0% (11)
25-34	27.9% (12)
35-49	29.1% (10)
<b>Relationship Status</b>	
Living with a husband/partner	79.8% (28)
Not living with husband/partner	20.3% (5)
<b>Total pregnancies</b>	
0	43.0% (11)
1-2	21.5% (8)
3-4	11.4% (5)
>4	24.1% (9)

**TABLE 5: LOCATION WHERE FAMILY PLANNING METHOD WAS LAST OBTAINED AMONG WOMEN WHO ARE CURRENTLY USING A MODERN FAMILY PLANNING METHOD, NAIROBI 2011 (N = 36)**

Method	% (n) women
Health centre	23.8% (10)
Hospital	44.0% (16)
Supermarket/Market	13.1% (3)
Pharmacy	17.9% (6)

**TABLE 6: KNOWLEDGE OF WHERE TO GET MODERN FAMILY PLANNING METHODS AMONG WRA WHO REPORTED HAVING HEARD OF THE METHOD, NAIROBI 2011**

Method	Health Centre % (n) women	Private clinic % (n) women	Market % (n) women	Friends/ relatives % (n) women	Pharmacy % (n) women	Don't Know % (n) women
Pill (N = 149)	39.7% (53)	27.8% (47)	2.6% (4)	6.4% (8)	14.7% (25)	7.4% (10)
IUD (N = 25)	32.8% (8)	16.4% (4)	11.9% (3)	7.5% (4)	20.9% (4)	10.4% (2)
Male condom (N = 205)	12.7% (25)	16.5% (37)	21.2% (41)	15.6% (32)	7.0% (15)	26.0% (53)
Female condom (N = 98)	7.1% (6)	5.0% (5)	11.1% (12)	11.4% (10)	6.1% (5)	58.6% (59)
Implants (N = 78)	30.1% (23)	25.4% (24)	1.0% (1)	2.9% (2)	25.8% (17)	14.8% (11)
Injectables (N = 172)	23.8% (40)	28.5% (52)	0.8% (2)	9.4% (15)	20.5% (32)	15.0% (27)
Emergency contraception (N = 21)	17.5% (4)	38.6% (9)	3.5% (1)	0.0% (0)	17.5% (3)	22.8% (4)
Tubal ligation (N = 10)	61.9% (5)	33.3% (4)	0.0% (0)	0.0% (0)	0.0% (0)	4.8% (1)

\*Percentages may add up to more than 100% as respondent may give more than one response.

**TABLE 7: PROPORTION OF WOMEN WHO ARE AT RISK FOR PREGNANCY,\* DESIRE TO STOP OR DELAY CHILDBEARING, AND ARE NOT USING FAMILY PLANNING AMONG WOMEN OF REPRODUCTIVE AGE, NAIROBI 2011 (N = 442)**

Indicator	% (n) women
Unmet need*	9.9%(41)

\*Women who are at risk for pregnancy are women who report being fecund, currently married, NOT pregnant and NOT postpartum.

**TABLE 8: MAIN PROBLEM REPORTED WITH USING SPECIFIC FAMILY PLANNING METHODS AMONG WOMEN WHO HAVE EVER HEARD OF THAT METHOD, NAIROBI 2011.**

<b>Method</b>	<b>Lack of access % (n) women</b>	<b>Opposition to use % (n) women</b>	<b>Method- related % (n) women</b>	<b>No problem % (n) women</b>	<b>Don't know % (n) women</b>
Pill (N = 149)	0.5% (1)	26.4% (40)	14.8% (23)	24.9% (37)	32.3% (45)
IUD (N = 25)	0.0% (0)	15.0% (3)	0.0% (0)	10.4% (5)	61.2% (15)
Male condom (N = 205)	0.3% (1)	11.6% (28)	1.5% (3)	18.0% (35)	61.3% (124)
Female condom (N = 98)	0.7% (1)	7.8% (8)	1.1% (1)	6.4% (8)	83.9% (80)
Implants (N = 78)	0.0% (0)	19.2% (16)	3.3% (2)	25.8% (22)	40.2% (31)
Injectables (N = 172)	1.2% (3)	23.4% (41)	12.1% (19)	21.3% (37)	36.5% (61)
Emergency contraception (N = 21)	0.0% (0)	12.3% (3)	8.8% (2)	38.6% (8)	40.4% (8)
Tubal ligation (N = 10)	0.0% (0)	9.5% (2)	19.0% (1)	14.3% (2)	57.1% (5)
Rhythm/calendar/counting days (N = 36)	2.3% (1)	15.9% (6)	0.0% (0)	43.2% (17)	27.3% (8)
Withdrawal (N = 71)	0.0% (0)	9.1% (9)	0.0% (0)	58.1% (43)	12.9% (8)
Other (N = 9)	0.0% (0)	0.0% (0)	16.0% (2)	56.0% (5)	8.0% (1)



**TABLE 9: REASONS MENTIONED FOR NOT USING A METHOD AMONG WOMEN WHO ARE CURRENTLY NOT USING A METHOD AND ARE CURRENTLY LIVING WITH A HUSBAND/PARTNER, NAIROBI 2011 (N = 219)**

<b>Reason mentioned</b>	<b>% (n) women</b>
Wants more children now	30.4% (69)
Currently pregnant	30.0% (71)
Religious prohibition	25.9% (58)
Husband opposed	20.6% (39)
Not having sex/infrequent sex	13.0% (25)
Breastfeeding	9.8% (17)
Unable/difficulty getting pregnant	6.1% (14)
Respondent opposed	6.1% (13)
Fears side effects	5.6% (10)
Knows no method	1.7% (4)
Knows no source	1.5% (2)
Hysterectomy	0.9% (2)
Other	0.4% (2)
Postpartum (up to 6 weeks)	0.4% (1)

*\*Percentages may add up to more than 100% as respondent may give more than one response.*

**TABLE 10: PROPORTION OF WOMEN WHO ARE NOT CURRENTLY USING A FAMILY PLANNING METHOD, BUT PLAN TO IN THE NEXT 12 MONTHS, NAIROBI 2011 (N = 382)**

<b>Indicator</b>	<b>% (n) women</b>
Intent to use family planning in next 12 months	6.3% (25)

**APPENDIX II: HEALTH FACILITY ASSESSMENT SUMMARY**

<b>TABLE 11: SUMMARY OF FACILITY ASSESSMENT FINDINGS, NAIROBI 2011</b>					
	<b>Topic</b>	<b>Indicator</b>	<b>Eastleigh City Council Clinic/UNHCR</b>	<b>Mother and Child Hospital</b>	<b>Marie Stopes Eastleigh Nursing Home</b>
<b>1</b>	Staffing	# of doctors or clinical officers providing any FP method	2	4	7
		# of midwives, nurse-midwives or nurses providing any FP method	27	13	12
<b>2</b>	Training	Proportion of doctors or clinical officers trained in FP among all doctors and clinical officers providing FP	0	0	100%
		Proportion of midwives, nurse-midwives or nurses trained in FP among all midwives, nurse-midwives or nurses providing FP	56%	15%	100%
<b>3</b>	Method Mix	# of temporary methods available	7	7	7
		# of long-acting methods available	2	2	2
		# of permanent methods available	0	2	2
		# of traditional methods promoted	2	2	3
		Is EC available?	Yes	Yes	Yes
<b>4</b>	Relative Score of Quality Measure	Score (out of 15)	11	12	14
<b>5</b>	Capacity to meet infection prevention standards	Score (out of 15)	13	14	14