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Fears, Misconceptions, and Side Effects of Modern Contraception in Kenya

Opportunities for Social and Behavior Change Communication

December 2012

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# ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>C-Change</td>
<td>Communication for Change</td>
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<tr>
<td>CHW</td>
<td>Community health worker</td>
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<tr>
<td>COC</td>
<td>Combined oral contraceptive</td>
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<tr>
<td>DRH</td>
<td>Division of Reproductive Health</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
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<tr>
<td>IDI</td>
<td>In-depth interviews</td>
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<tr>
<td>IUCD</td>
<td>Intrauterine contraceptive device</td>
</tr>
<tr>
<td>LAPM</td>
<td>Long-acting and permanent methods</td>
</tr>
<tr>
<td>MOPHS</td>
<td>Ministry of Public Health and Sanitation</td>
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<tr>
<td>SBCC</td>
<td>Social and behavior change communication</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TL</td>
<td>Tubal ligation</td>
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<td>y</td>
<td>Years of age</td>
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EXECUTIVE SUMMARY

Background and rationale
Increasing the uptake of modern contraception is critical to enabling women and their partners to reduce unmet need for family planning and to meet their fertility goals. Fears, misconceptions or misinformation, and side effects of methods (perceived or actual) are common barriers to the adoption and continuation of modern contraception. In Kenya, the total unmet need for spacing and limiting births is almost 26 percent, which reflects a sizable proportion of the population who are not meeting their fertility goals. While modern contraceptive use among currently married women has increased from about 27 percent in 1993 to 39 percent in 2009, there is also an increasing trend in reporting “fear of side effects” and “health concerns” as important reasons for non-use among younger women under age 30: a two-fold increase from 15.6 percent in 1993 to 30.7 percent in 2009. Understanding such barriers to fertility regulation is important for providing guidance to policymakers in decisions related to family planning. Between May 2011 and July 2012, the Communication for Change (C-Change) Project collaborated with the Division of Reproductive Health (DRH)/Ministry of Public Health and Sanitation (MOPHS) in Kenya on a qualitative research study to understand fear-related obstacles in the uptake and continued use of modern contraception, as well as the factors that may influence decisions for method choice. Although previous research has identified negative perceptions of contraception as reasons for non-use, this research sought to build on the evidence base and further explore these complex processes.

Objectives and questions
The research objectives were: 1) to document fears and misconceptions about family planning methods among men and women, and 2) to explore characteristics, decision-making factors, and processes among men and women who currently use modern contraceptives. The questions we asked under Objective 1 were: 1) what are people’s method-specific fears, and 2) what are the key drivers of these fears? Under Objective 2 the questions we asked were: 1) how do successful users overcome obstacles or barriers, and 2) what are the characteristics of successful users?

Design, methods, and data management
The study was conducted in two phases aligned with each research objective. Both phases were conducted with men and women 18–35 years of age in urban/peri-urban Kisii South and Kilifi districts in Nyanza and Coast provinces, respectively, where the unmet need for contraception is high, and where the modern contraceptive prevalence is roughly 32 percent.

In-depth interviews (IDIs) and focus group discussions (FGDs) were deployed for Objective 1 (Phase I) to explore shared normative perceptions among current users and non-users of modern contraception. For Objective 2 (Phase II) we only used IDIs, as we were interested in the personal experiences of current users of commonly available modern contraceptive methods (including pills, injectables, intrauterine contraceptive devices [IUCDs], implants, and condoms, and where applicable, permanent methods such as tubal ligation and vasectomy).

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3 Ibid.
Participants’ recruitment was linked to a public health facility providing modern contraceptive counseling services and methods. A facility offering contraceptive services and its catchment population were chosen to omit inaccessibility of services as a factor influencing contraceptive uptake.

Audio data were transcribed verbatim into MS Word files, translated into English, and imported into NVIVO 8 (QSR International Pty Ltd. Version 8, 2010), software to facilitate coding and analytical review including indexing, categorizing, and theorizing. We conducted analytical review of these interviews using the C-Change socio-ecological model\(^4\), to understand the differences between successful and unsuccessful contraceptive users.

**Key terms**
We use the terms contraception, family planning (FP), and contraceptives interchangeably to denote modern means of pregnancy prevention, child spacing, or birth limiting.

**Results**

*Participants’ characteristics and overview*
We attained 44 IDIs and 33 FGDs under Objective 1. The median age and years of education among IDI participants across the sites were 28 and 8, respectively, and were similar for FGD participants. However, participants in Kilifi appeared to be of lower ages, perhaps due to the practice of early marriage. Overall across the sites, younger and more educated men reported not using contraceptives, compared to their older and less educated counterparts.

Under Objective 2 we attained 71 IDIs with adult male (35) and female (36) participants currently using modern contraceptives including injectables (20), male condoms (17), hormonal contraceptive pills (13), implants (11), IUCDs (6), and female sterilization (4). Fifty-one of the participants were married. Nearly all (68) of the participants had formal education: 1–8 years (34), 9–11 years (8), and 12+ years (26).

The majority of participants across the sites were peasant farmers or housewives, and others were teachers and owners of small business enterprises.

*Participants’ understanding of contraception and contraceptive knowledge*
Contraception in general was viewed positively as the gateway to achieving life goals, particularly with the rising cost of living. The data suggested that people across the sites understood contraception to mean “having children by plan” including 1) among single persons, starting when one is ready to have children (i.e., in marriage), 2) spacing children to enhance both the health of mother and child, and 3) determining and limiting the number of children to a number one could provide for. In both study phases, women and men listed a range of contraceptive methods they generally knew of (mostly had heard of, if not already seen or used). The most commonly known method was pills, followed by injectables, and then condoms. Implants and IUCDs were mentioned but cited as methods about which little was commonly known. Data from Objective 2 (current users only) seemed to validate that users often only knew of the methods that they had tried before or were currently using.

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Fears generally associated with contraception, and drivers of these fears

Women and men across study sites discussed a wide range of fears categorized as 1) method complications, 2) undesirable physiological effects, and 3) negative economic and social consequences.

Method complications

Women and men’s discussions of method complications centered on the following themes: 1) potential for infertility, 2) contraceptive failure, 3) method expulsion or shift, 4) cancerous growths, and 5) birth defects. Participants linked many of these fears to specific methods, though not necessarily informed by personal experiences. Most discussions were punctuated by terms such as “You hear...,” and “I was told....” Except for condoms, which were perceived to be non-hormonal and therefore almost natural, prolonged use of all other contraceptives reportedly caused wounds in the womb, compromising fertility and birth outcomes, including failure to conceive and birth defects, respectively.

Pills and injectables were most often implicated in reported complications and were associated with infertility and cancerous growths. The two methods were also associated with increased chances of birth defects, especially should one fail to adhere to the pill regimen, or receive an expired injectable. Women cited cases of expired injectables leading to unintended pregnancies. Additionally, the effectiveness of injectables was deemed to diminish over time, leading to contraceptive failure.

A number of participants cited fear of method shift or expulsion in relation to implants and IUCDs. Individuals perceived that implants could get lost in the body via the blood stream. Similarly, the IUCD reportedly could shift from position during sexual intercourse, with serious implications for fertility and birth outcomes. Method shift would require surgery to remove, an outcome that was not only undesirable because of the invasive procedure, but also deemed costly.

“For the coil I have heard people say that they get lost inside the womb. For the implants I heard that there is a small operation and that is an issue in itself. The lady I know is a service provider who used an implant and when she wanted to have a child she couldn’t conceive... it got lost in the flesh until now she is barren.” (Male, 25y, user, IDI)

Undesirable physiological effects

The data highlighted several physiological effects—either participants’ perceptions or actual experiences—which spanned the entire gamut of modern contraceptive methods. These side effects included changes in weight and menstrual patterns, localized pain with regard to method administration of implants and IUCDs, changes in libido, high blood pressure, and shortness of breath, dizziness, or headaches. There were some differences among women and men in terms of side effects mentioned, but overall these themes cut across the large majority of focus groups and interviews.

“I have used injection... it got to a point [where] she [my partner] started complaining of backaches, feeling dizzy. And I also found myself being affected, because after going for one round, and even then I have to look for it [libido] like it is something that is lost. And after that it may take up to three days before attempting it again, and then when she does some small chore, she starts feeling bad.” (Male, 29y, user, FGD)

Though perceived to be non-hormonal and potentially safe because of this attribute, the IUCD reportedly trapped sperms, thus compromising a woman’s hygiene and putting her at risk of ovarian
problems. Importantly, its method of administration was perceived to be embarrassing, and reportedly a major contributor to its low uptake in both study sites.

“The issue of being naked and maybe it is a man putting it [IUCD]; so fear of the issue of someone seeing your private parts.” (Female, 26y, user, FGD)

Negative economic and social consequences
Negative social consequences were discussed more in terms of spousal relations and the role of marriage. Women’s and men’s fears appeared linked to two undesirable outcomes, including the inability to fulfill the reproductive role in the family, which was viewed as problematic given the high value that is placed on fertility, and the rising cost of living. These intertwined with severe social consequences including 1) economic and emotional strain in a relationship, 2) fear of spousal abandonment, and 3) general community stigma towards childlessness or birth limiting.

Fears of emotional and economic strain were discussed both in terms of an outcome of contraceptive failure (hence unintended pregnancies and increased family size) as well as the cost of treating method-related complications.

“Now you see… she has to go for an operation for it to be inserted, then if complications arise, another operation to remove it, so there are a lot of costs involved.” (Male, 24y, user, FGD)

Many women not using contraception suggested that while spousal objection to use was a factor, their overriding concern was with having no one to turn to in the family should complications later arise, including a serious medical problem such as cancer or a birth defect, and the related financial costs to remedy such a negative outcome. Women who overcame this fear sometimes opted for covert use of contraception, which could potentially mean taking up a method not necessarily medically suited but one offering the benefit of discreet use. Nevertheless, they seemed to opt for methods that presumably had minimal side effects.

“Mostly, because we do not let our husbands know, we choose the method that has few negative effects so that the husband does not know.” (Female, 34y, tubal ligation user, IDI)

Concerns about spousal abandonment extended to gender norms regarding a woman’s conjugal obligations to her spouse. Women’s fears of their partners taking on new sexual partners were fueled by several concerns: 1) perceptions that contraceptives reduced a woman’s libido so she would be unresponsive during sex, 2) a method perceived to have effects such as heavy bleeding or extended monthly menstrual period made her sexually unavailable to her partner, and 3) a method perceived to make a woman “over-lubricated” made her sexually undesirable to her partner.

“Before using this method we used to really enjoy sex and feel each other warmly, but things changed after using pills. You will just have sex with her...she is your wife...but you see she becomes so watery to a point of no enjoyment at all, and this even smells very bad.” (Male, 34y, partner of pill user, FGD)

“It [low libido] can [break up a home]... the husband may not understand. There are those who on seeing that their wives do not have an urge for them, they just walk out ready to seek other women.” (Female, 31y, discontinued injectable and implant user, IDI)
Concerns about social stigma were fueled by perceived community norms for not limiting births, failure to which a man was free to add another wife, or chase away his uncooperative wife.

**Whom do participants consult about health concerns and contraceptive side effects?**
Well over half of those we interviewed reported that peers (friends, neighbors, and relatives) and community health workers were their main sources of contraceptive information. The data also suggested that family planning was a private affair discussed only with close contacts. In Kisii, women particularly feared witchcraft, saying that knowledge that one was on contraception could make them a target for witchcraft, including bewitching existing children to death so that one is rendered childless. In Kilifi, women feared social scorn for being on contraception; a marriage is traditionally supposed to result in children, the more the better. These two fears made open contraceptive talk taboo in the two study sites.

> “What I know... the women in the village here when they are using a family planning method, it is not easy that they tell another that they are on a method because they fear that the other children that she has can be killed... the other children can die... so it is usually a secret between the doctor and the woman.” (Female, 35y, non-user, IDI)

> “Again there is a lot of belief in witchcraft so people prefer keeping to themselves, and issues of family planning are kept private between the husband and wife.” (Female, 32y, injectable user, IDI).

Often, based on initial consultations with peers and others, a decided prospective user would visit the health service with a preferred method already in mind, and wanting “fast service” lest other people learn the motive of the visit. Although interviews with participants in Kilifi suggested the full method mix was often presented for decisions, service providers indicated clients’ desire for “fast service” left little room to sensitize them on the full method mix, let alone offer adequate contraceptive counseling. The verbatim remark below illustrates this dilemma.

> “Women in the community talk and say, ’Today we will go for family planning’... your fellow women will tell you ’Myself, I am using injection’... the other one will go for injection and insist to the doctor that she wants injection... when the doctor tries to explain, she ignores.” (Female, 34y, user, FGD)

**How do successful users overcome their obstacles, opposition, and fears?**
The premise for Objective 2 (in-depth interviews with current FP users only) was that while fears and misconceptions inhibited the uptake and continuation of contraception, there were women and men successfully using family planning methods in these same communities. The findings suggest that factors facilitating the uptake of family planning exist at every level of the C-Change socio-ecological model: environmental, community, interpersonal, and individual.

**Environmental level**
The increasing cost of living and related economic constraints of raising a large family, cited in almost all IDIs, provided a significant incentive to space or limit births. The intrinsic motivation to avoid unintended pregnancy among married or single participants was in order to have a good life. Participants spoke of the desire to have the number of children they could provide for—feed, clothe,
educate, nurse, and provide better health care—and allowing the parents the time and space to engage in economic activities.

“Family planning is good as it helps in spacing of children, and this gives the couple more time to concentrate on other things like investing or your business.” (Unmarried female, age 20, non-user, FGD)

Some participants’ contraceptive uptake was reportedly triggered by the struggles and challenges that their neighbors with larger families faced; thus, the desired method needed to perform its specific function, including simply not failing, enabling birth spacing, or completely stopping more births. Participants in casual partnerships (unmarried young persons) wanted to avert pregnancy to secure or protect their future, including both completing school and increasing chances of getting married to the person of their choice.

Community level
The verbatim remarks below summarize how successful contraceptive users overcome obstacles and fears. While successful users considered social information in their initial method uptake, their subsequent uptake of the method or method switch were informed by both their personal observations and search for solutions to an identified potential hindrance. Importantly, they appeared to have a sustained relationship with health care providers. Engaging with the health service helped corroborate information, fostering a sense of trust that enabled individuals to not only understand how a method works and consult about fears and specific misconceptions, but also to explore options for method switching if they experienced intolerable side effects.

“We were told the pill is so bad, it has batteries. I thought that it can go and heap in my stomach. I then decided to use the injection because I had not heard so many negative things about it. After the injection I started bleeding... so I stopped using it... after talking with the doctors I went for the pills, and first I put a pill in water but it all dissolved and I did not see a battery inside. From then on I chewed the pill so that it can not stay in my stomach.” (Female, 30y, pill user, IDI)

“I always see it important that before you start using a certain method, you seek information about them. You get some education too, knowing that if you use this method then you have these advantages or if I do this then these are the side effects. So it’s very good and advisable you get educated more on these methods way before you use them.” (Male, 34y, partner of injectable user, IDI)

Interpersonal and individual levels
A notable feature among current users of contraception was the indication of partner dialogue and/or involvement throughout the family planning process. The verbatim remark below suggests that FP dialogue could be initiated by either of the spouses, and the negotiation process did not necessarily run smoothly. However, determined potential users appeared not to easily give up negotiations; they sought convincing arguments for their proposal to take up contraception. A female or male partner initiating discussion regarding FP appealed to their partner citing economic, health, and other benefits of FP use, depending on what they felt was most salient to their partner or partnership.
“It wasn’t a one day thing... because my partner wasn’t seeing the importance of family planning. She would ask, ‘why would you want to bring up this issue of family planning?’ After some time she finally understood... because we must have a family that we can take care of. So the gradual speed we took educating each other and making the decision to use family planning was not easy.” (Male, 32y, partner of injectable user, IDI)

Overall, spousal consultation was cited by most participants as a necessary step prior to any FP decision. Participants cited a number of reasons for engaging their spouse, including: mutual respect for their relationship, joint responsibility for current and future children, and fears about potential undesirable consequences of FP use.

“My husband is everything in my life so there is no way I would plan with someone else or alone, because if I get any problems I will tell him.” (Female, 28y, IUCD user, IDI)

How do contraceptives fit in the lifestyle of users?
Contraceptive choice seemed to be influenced by fertility desires at different stages of life, and desires for gender balance.

“If I would have gotten the first-born as a boy, or let’s say a girl and the second one a boy, I would have stopped there. But since I had not gotten... you know, according to our culture, if you do not get a boy, it is not very good.” (Male, 28y, condom user, IDI)

Unmarried men preferred using condoms both to protect against sexually transmitted infections and for pregnancy prevention, in case a girl was not honest about using contraception. Fear of sexually transmitted infections was reported more by young men in the coastal “red light district” of Mtwapa.

“...she may lie that she has taken the pills...at least with a condom you are sure; unlike if she tells you she has taken the pills, yet you were not there to prove it...so if you don’t use it you stand a great chance to face the consequences.” (Male, 23y, condom user, IDI)

Unmarried girls’ motivation for avoiding pregnancy was assurance of a future husband.

“I did not want to get pregnant again especially at home before marriage because another child would reduce my chances of getting married.” (Female, 20y, pill user, IDI)

Young married people appeared to prefer short-term FP methods, influenced by the desire to space children and considerations of how well the FP method suited the female spouse. Those married for 5 or more years, or those who had at least attained the desired family size, preferred using long-acting FP methods. Tubal ligation was likely to be considered by those with chronic illnesses and wishing to avoid further compromising their health with pregnancy. Informants who reported either being separated or divorced generally preferred not to have additional children and would choose long-term FP methods.

Discussion and implications for SBCC
Our study highlights from Objective 1 indicated that fears such as infertility, male impotence, birth defects, and cancerous growths were perceived as having severe social consequences. These potentially affected fertility and partner relationships and were a major detraction to the initial uptake of family planning, and potentially to the discontinuation of FP use altogether. On the other hand, while
physiological side effects such as weight gain, dizziness, headaches, high blood pressure, and even mild menstrual changes were considered bothersome and could in some cases lead to changes in normal functioning, these were not considered the key barriers to contraceptive uptake. Rather they were seen as reasons for choosing specific contraceptive methods and for switching from one method to another.

We think the distinctions made here are important ones, as they suggest that while individuals are concerned about the physiological manifestations of side effects, it is the social consequences of these contraceptive-related fears and misconceptions that may inhibit uptake and continuation, particularly the fear not only of infertility but also of community stigma toward childless marriages or birth limiting.

The premise for Objective 2 was that while fears and misconceptions inhibited the uptake and continuation of contraception, there were women and men who were successful users of FP methods in these same communities - indicating a potential to identify and replicate these positive behavior patterns in efforts to improve contraceptive uptake. Building on these findings, which are summarized at the various levels of the C-Change socio-ecological model, the discussion of opportunities for social and behavior change communication (SBCC) below cuts across these categories, including information, motivation, ability to act, and perceived social norms.

**Information**
This study highlighted lack of accurate information sources as a key driver of fears and misconceptions. Communication aimed not only at providing accurate information but also designed to address misconceptions, fears, and side effects, is an important step towards eliminating these barriers.

Along with tailored communication, promoting sustainable relationships with the health care community could establish mutual trust between individuals and the health service. Mechanisms that foster client-provider communication enhance continued FP use; a client that is comfortable asking questions about fears and method misconceptions, as well as reporting side effects, may be more likely to discuss options for contraceptive switching if needed, rather than opting for discontinuation.

**Motivation**
The intrinsic motivation to deter unplanned pregnancies among successful contraceptive users is what distinguished them from non-users. Motivation was discussed in varied forms including the economic challenges of raising additional children or children born too close together, and the desire to fulfill life goals that would be inhibited by unintended pregnancy. A communication campaign that addresses the variety of reasons that drive individuals to use family planning and avoid unintended pregnancy enhances the opportunity to motivate nonusers by targeting benefits that they may not have previously considered.

**Ability to act**
Male partners, by virtue of their decision-making power and control of financial resources, play a crucial role in the uptake and successful continuation of family planning methods. In both phases of this study women attributed low or late contraceptive uptake to their partners’ reluctance, with some compelled to use covert methods. Significantly, the majority of current users attributed their successful continuation of FP use to partner communication. This underscores the critical need to program male involvement both in uptake and in advocacy, especially to foster communication with partners and providers about side effects and more appropriate contraceptive switching when needed.
**Perceived norms**
While successful users mostly reported talking to providers about modern contraception and method choice decisions, the majority of participants overall indicated their family planning “knowledge” came from what they heard among their peers. The perception that family planning was a “private” matter points to the need to promote community acceptance of modern contraception. Traditional norms favoring large families still pose a barrier to the adoption of family planning. However, it appears that these norms may be changing, namely due to the economic environment, offering an opportunity to dissolve the fear of community or social stigma that some may associate with using contraception.

**Conclusions and potential application of findings**
This qualitative study has attempted to unpack key factors contributing to fears, misconceptions, and misinformation related to modern contraception and side effects, and the potential for addressing these barriers through SBCC. Results from this research can be used to create guidelines and recommendations for developing evidence-based SBCC interventions to promote use of modern methods available in Kenya. Notably, individuals and couples indicate growing receptivity to the concept of contraception, both for spacing and limiting births. An approach going beyond the generic provision of correct information remains of particular importance. Targeted communication should be designed to address questions regarding:

1) The common interaction between misconceptions, side effects, and the lack of accurate information, often results in a disproportionate fear of modern contraceptive methods. Consideration of the decision-making process to understand how contraception fits in the lifestyles and fertility intentions of individuals and couples may enhance tailored family planning counseling and improve uptake and continuation. In parallel, it is critical to focus on the more practical outcomes and draw attention to previously less recognized benefits such as a “manageable” family size – as increasingly important in view of the rising cost of living and limited land resource. In February 2012, the Kenya National Council for Population and Development (NCPD) launched a campaign with this message, shifting the focus from national development benefits to household-level benefits. Monitoring the process and effectiveness of such targeted communication is critical to decisions around the development and implementation of similar family-focused approaches to engendering contraceptive uptake.

2) The wider social and environmental issues surrounding women, such as the distribution of power and authority, which are in turn shaped by gender specific norms outside of and within relationships. It remains critical to look for innovative ways to address communication barriers surrounding contraception. This is especially needed because decisions around contraceptive uptake are not just about family size, but may also have financial implications including service fees for certain methods – factors traditionally in men’s control. Strategies to increase the involvement of men in reproductive health, particularly in family planning dialogue, serve to create an enabling environment that may be the step towards not only empowering women to negotiate for contraceptive use, but also reducing social communication barriers surrounding family planning. Kenya’s National Reproductive Health Strategy 2009-2015 targets male involvement through gender mainstreaming. Multiple approaches have been deployed in this effort, including creation of male-friendly family planning clinic environments, and community family planning outreach dialogue sessions facilitated by trained community health extension workers. Questions that should be answered to improve programming are the extent to which men are accessing FP clinics, and the levels of men’s and women’s participation in community dialogues. The reactions of men and women, including motivations and barriers, provide important to lessons for what works in which environment, and why – all important for further targeted intervention.
CHAPTER 1: INTRODUCTION

1.1 Background and rationale
Increasing the uptake of modern contraception is critical to enabling women and their partners to reduce unmet family planning (FP) need and to meet their fertility goals. Common barriers to the adoption and continuation of modern contraception include fears, misconceptions or misinformation, and side effects of methods (perceived or actual).[1–3] Although many contraceptive methods have actual side effects that may pose barriers to contraceptive initiation or influence contraceptive discontinuation, perceptions of side effects are also an important barrier largely based on misinformation or misconceptions.[1] In particular, the common interaction between misconceptions or misinformation, side effects, and the lack of accurate information often results in a disproportionate fear of modern contraceptive methods.[1]

Many studies conducted in sub-Saharan Africa have documented that perceived contraceptive side effects are a common and important barrier to adopting modern FP methods. Common fears and misconceptions are cited as reasons for non-use in various studies and include the following: hormonal contraceptives cause cancer [4, 5], menstrual disruption, infertility [6, 7], and weight gain/loss; implants can travel throughout the body and become lost; and condoms cause cancer and contain harmful bacteria.[8] Less has been documented, however, about what drives these fears and what motivates some users to overcome their fears to initiate and continue contraceptive use. Research has tended to focus on the socio-demographic characteristics of users of contraception. For example, a hospital study in Nigeria identified that acceptance of the intrauterine contraceptive device (IUCD) was most common among multiparous clients, the majority of whom were married, Christian, and had at least secondary school education.[9] However, the literature does not provide an understanding of the decision-making process related to the use of modern contraception. Although those not using contraceptives may have fears about detrimental side effects or other health concerns, it is also possible that those using contraceptives share similar concerns, but for whatever reasons, are not as sensitive to these views.[2, 10]

In Kenya, women and families suffer from unnecessary health problems and bear heavy economic burdens as a result of high fertility and suboptimal timing and spacing of pregnancies. While Kenya has achieved notable progress in family planning over the years [3], a critical challenge remains in ensuring that gains in family planning continue to improve and are sustained. The Kenya Demographic and Health Survey (KDHS) over the years indicates an increasing trend in the proportion of women who cite “fear of side effects” and “health concerns” as important reasons for not using contraception. “Fear of side effects” remains a persistent barrier, reported in the 2003 and 2008–09 KDHS as the primary reason for not using contraception.[3, 11] A review of available literature suggests absence of data on how perceived side effects and fears play a role in the decision to use (or not use) modern contraception. Recent research on fear of side effects appears aligned to long-acting and permanent methods (LAPMs) [12], and post-abortion services assessing the potential role of emergency contraception.[13, 14] Notably, while the focus on LAPMs is understandable, due to their greater efficacy and cost effectiveness, recent trends in the KDHS indicated user and provider preference for short-acting methods.[3, 11]
Between May 2011 and July 2012, the Communication for Change (C-Change) Project collaborated with the Division of Reproductive Health (DRH)/Ministry of Public Health and Sanitation (MOPHS) in Kenya in a qualitative research study to explore barriers to contraception and to examine the role they play in relation to contraceptive decision-making. It is expected that a comprehensive assessment of fears related to the full range of modern contraceptive mix in the Kenya family planning service would build on the evidence base for strategic social and behavior change communication (SBCC) interventions toward overcoming barriers—with potential benefits to the promotion of long-acting and permanent methods as well as prevention of unintended or unwanted pregnancies. This report outlines the qualitative research findings, conclusions, and recommendations.

1.2 Definitions
In this report we interchangeably use the terms contraception and family planning to denote planning whether and when to have children, and the use of birth control and other techniques to implement such intentions. Similarly, the terms contraceptives, contraceptive methods, and family planning methods are interchangeably used to denote modern methods of birth control.

Also, we use the terms Phase I and Phase II to align with the sequential plan for data collection relevant to the two study objectives.

1.3 Objectives and study questions
The broad objective was to develop a better understanding of fears, misconceptions and misinformation, and perceived side effects related to the use of modern contraception among eligible adults 18–35 years in Kenya. There were two specific objectives:

1. To document shared normative contraceptive perceptions, fears, and experiences among current users and non-users of modern contraception.
2. To explore individual experiences, decision-making factors, and processes among current users of modern contraception.

Five key research questions guided explorations:
1. What are the key drivers of FP fears?
2. What are the method-specific fears?
3. How do successful users overcome obstacles, opposition, and fears?
4. What characteristics do successful users perceive as desirable in their current method?
5. How do contraceptives fit within the lifestyles of successful users?

1.4 Study design

1.4.1 Study locations and population
The study was conducted among ethnically mixed populations in urban/peri-urban Kisii South and Kilifi districts in Nyanza and Coast provinces (Figure 1), respectively, where the unmet need for contraception is high. Modern contraceptive prevalence in Nyanza is 32.9 percent and total unmet need 31.7 percent. In Coast, these are 29.7 percent and 25.4 percent, respectively. The regions were selected following consultations with the Family Planning Research Technical Working Group chaired by the Ministry of Health. Kilifi was selected due to the rich mix of cultures in the Kilifi-Malindi region, thus deemed to provide a wide perspective of people’s perceptions of modern contraception. Kisii South was selected on the basis that it is one of the least researched sites in the Nyanza region, and therefore less is known.
in terms of reproductive health issues. The specific study population was men and women 18–35 years, including current, discontinued, and never users of modern contraception.

**Figure 1: Study locations**

![Study locations diagram]

### 1.4.2 Selection of specific data collection sites

The DRH provided introductory letters to relevant MOPHS authorities in the respective provinces and districts. The study team made courtesy calls with key personnel of the District Health Management Teams, including the District Medical Officers, DRH Coordinators, and District Public Health Nurses. Consultations included selection of specific data collection sites. Considerations for site selection included:

- Public health facilities, one with an urban outlook and one with a peri-urban outlook.
- Facilities with a high client load and currently providing comprehensive contraceptive services including counseling and the full range of contraceptive methods (pills, implants, injectables, IUCDs, condoms, bilateral tubal ligation, and vasectomy).
- Facilities supported by a community health unit including presence of community health workers, and community health extension workers to facilitate entry into the health facility catchment area for recruitment of additional participants that may not attend health service during the study period.

Subsequently, Kilifi sites were determined as Ganze (peri-urban) and Mtwapa (urban) health centers. Kisii South sites were determined as Iyabe sub-district hospital (peri-urban) and Nyamagundo health center (urban).

### 1.4.3 Methods and sample

Focus group discussions (FGDs) and in-depth interviews (IDIs) were deployed to generate insight on normative perceptions and/or experiences of non-users and users of contraception (Objective 1). For Objective 2 we used only in-depth interviews, as the interest was with personal experiences of current users. Objective 2 interviews focused on the experiences of the use of five modern contraceptive

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*v Recruitment of study participants within the health facility’s catchment area was restricted to a radius of five (5) kilometers, informed by national health facility guidelines on the distance that people are likely to walk while seeking health care.
methods commonly available in Kenya: the hormonal contraceptive pill, injectable contraceptive, IUCD, implant, and condoms (and where applicable, permanent methods such as tubal ligation and vasectomy). The *a priori* data collection plan is highlighted in Table 1 below.

### Table 1: Study sample plan

<table>
<thead>
<tr>
<th>Objective 1. In-depth interviews (32)</th>
<th>Site one</th>
<th>Site two</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Users Discontinued or Never-users</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Men</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Users Discontinued or Never-users</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

| Objective 1. Focus group interviews (32)       |          |          |       |
| Women                                         | 8        | 8        | 16    |
| Men                                           | 8        | 8        | 16    |

| Objective 2. In-depth interviews (60)          |          |          |       |
| Current users of each of 5 modern methods      | 6/method (30) | 6/method (30) | 60    |

The sample was flexible; participants were recruited continuously until the point of saturation (i.e., when no new insights were generated), as well as to supplement several interviews if participants appeared inarticulate on issues of contraception.

1.4.4 Procedures

Data was collected in two phases, each aligned to a study objective. Data for Objective 1 (henceforth referred to as Phase I) was collected first and preliminary findings were used to finalize study guides and field logistics for data collection under study Objective 2 (henceforth referred to as Phase II).

**Interviewer training and pre-test**

Study team training was conducted sequentially in alignment with the two study phases. For Phase I, fourteen (14) qualitative data collection staff participated in a 4-day training including 3 days of theory and role play and 1 pre-test day in early November 2011. The training topics included the study background, objectives, and design; survey data collection tools; data security and confidentiality; accurate translation and transcription of field notes and audio data; and informed consent procedures. Training included extensive role play and practice, as well as emphasis on research ethics and the rights of potential participants. Training was led by a data collection subcontractor, with the oversight and guidance of C-Change and DRH representatives. DRH staff also conducted a session overview of the contraceptive method mix available in Kenya. The pre-test was conducted at a public health facility offering contraceptive services on the outskirts of Nairobi. The same process of training was conducted with eight data collectors for Phase II in early February 2012.

**Participant recruitment**

Participants’ recruitment was linked to the four public health facilities providing modern contraceptive counseling services and methods. They were recruited from health clinics and from clinic catchment areas (within a 5 kilometer radius); from among clients of the services, with assistance from nurses in the clinics; and through snowball sampling in the community, with the assistance of community health...
workers (CHWs). This was to minimize bias toward interviewing only persons who attend health services. Also, to ensure a cross-section of participants, clinic- and community-based recruitment and interviews ran concurrently. Clinic personnel and CHWs were instructed to maintain the privacy and confidentiality of individuals they helped identify for possible participation in the study. A participant screening sheet was deployed to ensure samples of IDI participants and FGD participants did not overlap during Phase I interviews. A similar participant recruitment approach was deployed in Phase II to ensure participants did not overlap with those interviewed in Phase I.

**Data collection and validation**
The study team made appropriate courtesy calls with the respective health facility in-charges and secured their endorsement and support for the data collection exercise in both study phases. Interviews were conducted in Kiswahili in both sites, with interviews in Kilifi being intertwined with the local Miji Kenda dialects. All interviews were digitally recorded to aid accurate transcription of notes.

Data was collected by a commercial research firm selected through a standard competitive bids system. Notably, the trained interviewers were split in half and deployed as a team to each study location. Data collection commenced at one specific site in each location, beginning with the peri-urban sites and then relocating to the urban sites. Participants were interviewed by same-sex interviewers to increase informant ease with responding to personal questions that may be easier to discuss with an interviewer of the same gender. All interviews were audio-recorded, transcribed, and translated into English.

C-Change and DRH staff and a study coordinator from the data collection firm accompanied the field team during data collection start-up at each study phase (for 3 days per study location) to provide immediate on-site support as needed. The teams held debrief sessions at the end of each field day to review progress with participant recruitment and to verify adequacy of questions to generate desired answers. Probing skills were also assessed and advice provided for improvement or for exploring emerging topics.

**Data management, entry, and analysis**
Data was translated to English from Kiswahili as it was transcribed. Data was word processed into MS Word files. Analytical review of the data followed standard procedures for qualitative methods: a flexible, iterative process involving a search for patterns and concepts that help explain the patterns. Transcripts were reviewed to identify similar phrases, relationships between variables, patterns, themes, distinct differences, and common themes, and to create conceptual clusters.

A code book was developed from key themes and patterns identified. MS Word transcripts were imported into NVivo software for coding, cross-classification, and retrieval of transcripts and segments of text by theme. We reviewed themes and interpretations, analyzing discrepancies and contradictions, and systematically searching for supporting evidence and counter-evidence related to each interpretation. Notably, discrepant findings were deemed not to necessarily suggest methodological weakness, but rather a reflection of multiple realities—contradictory yet valid perspectives and experiences in the study populations. The C-Change socio-ecological model (Figure 2) was used to interpret the differences between successful and unsuccessful contraceptive users.

Finally, the data collection firm, C-Change, and DRH conducted a participatory analysis workshop to review the themes and brainstorm preliminary conclusions regarding the fears, misconceptions, and side effects related to modern contraception.
*These concepts were originally developed for the individual level. However, they apply to all levels (interpersonal, community, enabling environment)

CHAPTER 2: DEMOGRAPHIC AND SOCIAL CHARACTERISTICS OF PARTICIPANTS

2.1 Phase I

In-depth interviews
We conducted 45 IDIs: 24 in Kisii South and 21 in Kilifi, summarized in Table 2. Additional interviews were included to supplement scanty information from young persons and women who appeared to have little information regarding contraceptive methods. The median age among participants across the sites was 28 years, and was lower in females (25 years) than men (29 years). The median number of years of education was 8. Although lower educational attainment was recorded among females than men, the median years of education were comparable at 7.5 and 8 for women and men, respectively. It appeared that current users of modern contraception had a lower educational attainment compared to non-users. The trend was similar for Kisii South and Kilifi. A majority of the participants were peasant farmers or housewives, with a few teachers and businessmen.

Table 2: Sample and socio-demographic characteristics of IDI participants

<table>
<thead>
<tr>
<th>Site</th>
<th>Gender</th>
<th>User Status</th>
<th>Count</th>
<th>Age Median (IQR)</th>
<th>Education Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Current users</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-users</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kisii</td>
<td>Female</td>
<td>Current users</td>
<td>10</td>
<td>25 (24,33)</td>
<td>7.5 (6,8)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Non-users</td>
<td>5</td>
<td>24.5 (23,28)</td>
<td>10 (7.5,12)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Current users</td>
<td>4</td>
<td>26.5 (21.5,29)</td>
<td>6 (7,8)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Non-users</td>
<td>5</td>
<td>28 (28,28)</td>
<td>12 (10,13.5)</td>
</tr>
<tr>
<td>Kilifi</td>
<td>Female</td>
<td>Current users</td>
<td>10</td>
<td>28.5 (25,30)</td>
<td>7 (1,8)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Non-users</td>
<td>6</td>
<td>23 (19.5,30)</td>
<td>1 (0,12)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Current users</td>
<td>4</td>
<td>30 (30,30)</td>
<td>12 (8,12)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Non-users</td>
<td>1</td>
<td>28.5 (25,29.5)</td>
<td>Not Available</td>
</tr>
<tr>
<td>Total</td>
<td>Female</td>
<td>Current users</td>
<td>20</td>
<td>26.5 (24.5,32)</td>
<td>7.5 (4,8)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Non-users</td>
<td>11</td>
<td>24.5 (23,28)</td>
<td>7.5 (0,12)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Current users</td>
<td>8</td>
<td>30 (28,30)</td>
<td>8 (6.5,10)</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Non-users</td>
<td>6</td>
<td>28 (28,29)</td>
<td>12 (10,13.5)</td>
</tr>
</tbody>
</table>

Focus group discussions
We attained 33 FGDs including 17 discussions in Kisii South and 16 in Kilifi. Table 3 summarizes participant count and other socio-demographic information by age groups 18–24 years and 25–35 years. The median age in FGDs was 27 years, with no gender differences. On average the level of education was around 8 years, with the same patterns among male and female participants. However, participants in Kilifi were generally younger, attributable to the practice of early marriage. Younger and more educated men reported not using contraceptives, compared to their older and less educated counterparts. There appeared to be no difference in the level of education among female users and non-users of modern contraception. The majority of participants across all FGDs were peasant farmers, businessmen, housewives, or teachers, in that order.
Current FP users reported using FP methods for periods ranging from less than 1 month to 16 years, and the median number of years of use was 2 years. Since participants included unmarried youth, the number of children varied from zero to seven children.

Table 3: Sample and socio-demographic characteristics of FGD participants

<table>
<thead>
<tr>
<th>Site</th>
<th>Gender</th>
<th>Age Group</th>
<th>Count</th>
<th>Median Age</th>
<th>Education Median (IQR)</th>
<th>Years of FP Use Median (IQR)</th>
<th>Number of Children Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisii</td>
<td>Female</td>
<td>18-24y</td>
<td>19</td>
<td>26 (24,29)</td>
<td>10 (8,11)</td>
<td>3 (1.5,5)</td>
<td>3 (2,4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25-35y</td>
<td>59</td>
<td></td>
<td>8 (8,12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>18-24y</td>
<td>10</td>
<td>27 (23.5,31)</td>
<td>10 (8,12)</td>
<td>2 (1,4)</td>
<td>2 (1,3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25-35y</td>
<td>36</td>
<td></td>
<td>8 (98,12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kilifi</td>
<td>Female</td>
<td>18-24y</td>
<td>16</td>
<td>28 (25,32)</td>
<td>7.5 (3,9.5)</td>
<td>2 (0,3)</td>
<td>3 (2,5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25-35y</td>
<td>33</td>
<td></td>
<td>6 (0,8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>18-24y</td>
<td>22</td>
<td>28.5 (25,32)</td>
<td>12 (8,12)</td>
<td>29 (1,3)</td>
<td>1 (1,2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25-35y</td>
<td>38</td>
<td></td>
<td>8 (7,12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Female</td>
<td>18-24y</td>
<td>34</td>
<td>27.5 (24,32)</td>
<td>8 (6,11)</td>
<td>2 (1,5)</td>
<td>3 (2,4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25-35y</td>
<td>94</td>
<td></td>
<td>8 (6,11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>18-24y</td>
<td>32</td>
<td>27 (24,32)</td>
<td>12 (8,12)</td>
<td>2 (1,3.5)</td>
<td>2 (1,3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25-35y</td>
<td>74</td>
<td></td>
<td>8 (8,12)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.2 Phase II (in-depth interviews)

We conducted 71 IDIs; 37 in Kilifi and 34 in Kisii South, distributed in Table 4 by the current modern contraceptive method. Most of the participants interviewed were currently injectable users, followed by users of hormonal contraceptive pills, condoms, and implants. Each study site had at least two participants currently using IUCDs and at least 2 who had undergone tubal ligation. Slightly more interviews were conducted in Kilifi on account of participants not being very articulate on issues regarding contraception despite the fact they may be current users.
Table 4: In-depth interviews attained in Phase II, by contraceptive method

<table>
<thead>
<tr>
<th>Kilifi</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ganze</td>
<td>Mtwapa</td>
<td>Iyabe</td>
<td>Nyamagundo</td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>(N=20)</td>
<td>(N=17)</td>
<td>(N=17)</td>
<td>(N=17)</td>
<td>(N=35)</td>
<td>(N=36)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
</tr>
<tr>
<td>Injectable</td>
<td>8(40)</td>
<td>4(24)</td>
<td>4(24)</td>
<td>4(24)</td>
<td>7(20)</td>
<td>13(36)</td>
</tr>
<tr>
<td>Implant</td>
<td>4(20)</td>
<td>1(6)</td>
<td>4(24)</td>
<td>2(12)</td>
<td>3(9)</td>
<td>8(25)</td>
</tr>
<tr>
<td>COCs (pill)</td>
<td>1(5)</td>
<td>5(29)</td>
<td>1(6)</td>
<td>6(35)</td>
<td>5(14)</td>
<td>8(22)</td>
</tr>
<tr>
<td>Condom</td>
<td>3(15)</td>
<td>7(41)</td>
<td>4(24)</td>
<td>3(18)</td>
<td>17(49)</td>
<td></td>
</tr>
<tr>
<td>IUCD</td>
<td>2(10)</td>
<td>-</td>
<td>3(18)</td>
<td>1(6)</td>
<td>1(3)</td>
<td>5(14)</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>2(10)</td>
<td>-</td>
<td>1(6)</td>
<td>1(6)</td>
<td>2(6)</td>
<td>2(5)</td>
</tr>
</tbody>
</table>

Table 5 summarizes selected socio-demographic information of the 35 male and 36 female current users of modern contraception. Fifty-one of the participants were married. Nearly all (68) of the participants had formal education: 1–8 years (34), 9–11 years (8), and 12+ years (26). Slightly over half of the participants (42) reportedly had no occupation (formal employment) although they engaged in activities such as peasant farming, housekeeping, and casual labor. The other main occupation was running a small business (14). The participants’ age groupings were summarized at analytical review as ≤ 25 years (20), 26–30 years (25), and >31 years (26).
Table 5: Socio-demographic characteristics of current users of contraception

<table>
<thead>
<tr>
<th></th>
<th>Kisii South</th>
<th>Kilifi</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
<td>18</td>
<td>35</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td><strong>Education (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>1–8</td>
<td>17</td>
<td>17</td>
<td>34</td>
</tr>
<tr>
<td>9–11</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>12+</td>
<td>11</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>30</td>
<td>21</td>
<td>51</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Single</td>
<td>4</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td><strong>Desired number of children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–2</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>3–4</td>
<td>24</td>
<td>19</td>
<td>43</td>
</tr>
<tr>
<td>5+</td>
<td>7</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed (Peasant farmer, Housewife, student)</td>
<td>23</td>
<td>19</td>
<td>42</td>
</tr>
<tr>
<td>Social worker</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Small business</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Casual laborer</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Driver</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Electrician</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mechanic</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>School matron</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Security guard</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Tailor</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Teacher</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Technician</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
CHAPTER 3: STUDY FINDINGS

This section outlines the findings from our qualitative research and uses verbatim quotes to add insight into these observations. The contraceptive use status of persons quoted in the text is specified either as user, non-user, or discontinued user. Effort has also been made to state the methods of users, although this is not possible in every instance a verbatim quote has been used. Notably, some in-depth interview participants in Phase I of the study declined to divulge the specific method they were using, and it was practically difficult to collect this information in focus group discussions. However, the specific methods used by participants in Phase II in-depth interviews were recorded and have been specified for every verbatim remark appertaining to findings from the second phase of the study.

3.1 What influences fertility desires and family sizes?

This section describes current family sizes and fertility desires and some of the factors underlying participants’ decisions related to contraception. Data from both study phases indicated relatively large family sizes, ranging from 1 to 12 children.

3.1.1 What are the current and desired family sizes?

In Kisii south, the current number of children among participants ranged from 3 to 12, although the average number ranged from 4 to 6.

“...with the way years are progressing and how life is at the moment, and even farming land has become small, I would say about five children. That is a good family, because things have become hard.” (Male, 30y, partner of injectable user, IDI)

A larger number of children in families in Kisii, particularly those with more daughters than sons, was attributed to couples continually trying for sons to fulfill perceived social recognition of sons as completing a marriage.

“...some value a boy child very much. So if maybe he has three daughters, he must try so much to get a boy... because he sees a boy is the one who will help him. Because girls will get married, it is like cultivating someone else’s farm. So trying to get a baby boy contributes so much to getting many children... Mostly it is boys that will sustain your marriage.” (Male, 28y, user, FGD)

On the other hand, participants in Kilifi appeared inclined to have more children, with the average number of children estimated at 6 to 8. Large family sizes, especially in the more rural Ganze, was reportedly occasioned by perceived social pressure to fulfill kinship naming desires, with implications for whether a woman would consider contraception.

“I think there is that tradition of the mijikenda that you get children according to the number of parental relatives you may have. If your father had more than one brother then you get according to their number and even the mother... that’s what is going on here in this community.” (Male, 33y, non-user, FGD)

Despite the above cited specific nuances in factors influencing family sizes, interviews in Phase I suggested no distinct pattern in the number of children desired, with indication that these were dependent on individual preferences and a mix of personal, health, and social circumstances.
“It depends with each individual’s income and ability since this one can have four children and is able to nurture them and another has only one and is not able to feed even that one alone. Some women have four children and they are still very young... have not even reached menopause... and they decide those are enough, but upon trying family planning methods they backfire on her so she stops family planning due to side effects and just continues giving birth.” (Female, 24y, user, FGD)

3.1.2 What factors influence fertility desires? How do these interweave with contraceptive decisions?
Focus group discussions in both Kisii and Kilifi suggested that persons with at least a primary level of education were likely to prefer fewer children than their counterparts without formal education. This was contrary to demographic information indicating that non-users of contraception among men were less educated than their male counterparts reporting contraceptive use. Similarly, persons perceived to be economically stable were reported as tending to have fewer children.

“... It depends... for example, you will find the ones educated have fewer children” (Female, 31y, user, FGD)

“...but again depending on the homestead/family, wealth counts greatly. You will find those that are well up (economically stable) have fewer children than those that are not so well up.” (Female, 23y, user, FGD)

Interviews prioritizing current contraceptive users (Phase II) asked participants to identify any consideration that went into their decisions regarding family size and related contemplations prior to uptake of contraception. Participants discussed these in relation to their life goals, the potential role of contraception, as well as specific contraceptive method preference considerations. Table 6 summarizes the distribution of participant responses for key considerations.

<table>
<thead>
<tr>
<th></th>
<th>Ganze (n=20) N(%)</th>
<th>Iyabe (n=17) N(%)</th>
<th>Mtwapa (n=17) N(%)</th>
<th>Nyamagundo (n=17) N(%)</th>
<th>Male (n=35) N(%)</th>
<th>Female (n=36) N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Concerns</td>
<td>15(75)</td>
<td>12(71)</td>
<td>14(82)</td>
<td>13(76)</td>
<td>27(77)</td>
<td>27(75)</td>
</tr>
<tr>
<td>Child Spacing</td>
<td>3(15)</td>
<td>1(6)</td>
<td>-</td>
<td>1(6)</td>
<td>3(9)</td>
<td>2(5)</td>
</tr>
<tr>
<td>Gender Preferences</td>
<td>2(10)</td>
<td>1(6)</td>
<td>1(6)</td>
<td>2(12)</td>
<td>4(14)</td>
<td>2(5)</td>
</tr>
<tr>
<td>Kinship naming practices</td>
<td>1(5)</td>
<td>-</td>
<td>1(6)</td>
<td>-</td>
<td>1(3)</td>
<td>1(3)</td>
</tr>
</tbody>
</table>

Duration in marriage, birth limiting, and child gender preferences
Discussions with Phase II participants also suggested patterns of influence between marriage, current and future fertility desires, current economy, and decisions regarding contraception (Table 7).

Among married participants, the duration in marriage appeared to influence fertility desires and contraceptive method choices. Participants in a young marriage (up to 5 years) had 1–2 children, used contraception for child spacing, and appeared to prefer short-term contraceptive methods including
pills, injection, and to some extent implants (1-year implant). While participants in a young marriage suggested they generally would be fine with 2–4 children in view of current economic hardships, those in Kisii South reportedly would consider having more children until they attained a desired gender, with suggestions that having a male child was paramount.

“If I would have gotten the first born as a boy, or let’s say a girl and the second one a boy, I would have stopped there. But since I had not gotten... you know, according to our culture, if you do not get a boy, it is not very good.” (Male, 28y, condom user, IDI)

Table 7: Marital status, fertility desires, and contraception

<table>
<thead>
<tr>
<th></th>
<th>Never married</th>
<th>Married 1–5y</th>
<th>Married &gt;5 years</th>
<th>Separated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current child count</strong></td>
<td>nil</td>
<td>1–2</td>
<td>3–10: Higher counts in Kilifi</td>
<td>1–6</td>
</tr>
<tr>
<td><strong>Desired # children</strong></td>
<td>2–4 with gender balance</td>
<td>2–4: would try for boys if have girls</td>
<td>Kisi: 4–6</td>
<td>May add more if remarried</td>
</tr>
<tr>
<td><strong>Gender balance or preference</strong></td>
<td>Desire 2 children with gender balance</td>
<td>Strong in Kisi, BUT new couples report not an issue</td>
<td>Would try for boys if have girls: part reason for &gt;4 children in Kisi</td>
<td>May consider if remarried</td>
</tr>
<tr>
<td><strong>Motivation</strong></td>
<td>Avoid STI/ pregnancy Avoid stigma/ secure future</td>
<td>Child spacing Current economic strain</td>
<td>Limit births/ stop completely; Current economic strain</td>
<td>General hardships of single parenting</td>
</tr>
<tr>
<td><strong>Method preference</strong></td>
<td>Male: Condoms Female: None. Injections or implants if must.</td>
<td>Short-term FP: pills, injections, and 1y implants</td>
<td>Injections and LAPMs: 5y implants, IUCD, or TL</td>
<td>Injections and LAPMs: 5y implants, IUCD, or TL</td>
</tr>
</tbody>
</table>

Persons with more than 5 years in marriage had 3–10 children, with somewhat higher fertility desires in Kilifi than Kisii south. Within Kilifi, participants in Mtwapa reported lower fertility desires (2–4 children) than their more rural counterparts in Ganze who desired 4–5 children. These were attributable to urban setting influence and cost of living (Mtwapa) and perceived social pressure to have many children in order to fulfill kinship naming desires (Ganze).

Married participants who had at least attained the desired family size or gender mix appeared to prefer long-acting contraceptive methods such as the 5-year implant and to some extent, IUCD. Some would also consider permanent methods, though these remained very unlikely choices for both women and men due to certain fears.

“There is fear for a woman [who has undergone tubal ligation]...supposing one had fewer children and maybe he had one son...and sons are preferred...let’s say by bad luck the son dies...the man will want to marry again since he knows that the wife cannot give birth anymore. That is why women prefer other family planning methods and not permanent.” (Female, 32y, user, FGD)

“Your woman will get to a point she may look down on you [because you had a vasectomy]... she will start feeling like you cannot perform, and you will start hearing stories that she was with
someone [another man] somewhere. So you will start thinking in your mind...if only I was well... maybe she is doing this to me because she knows how I am...” (Male, 29y, user, FGD)

Thus, tubal ligation appeared to be the more likely choice of a couple that had chronic illness or HIV and wished to avoid further compromising the health of the female partner in case conception occurred. Unless they remarried, informants who reported either being separated, divorced, or widowed generally preferred not to have additional children and would choose long-acting contraceptive methods, if not a permanent method like tubal ligation.

**Young adults securing future life goals**

Contraceptive use among young single persons (never married) was reportedly motivated by desire to “secure their future.” Young men preferred condoms both to protect against sexually transmitted infections (STIs) and pregnancy prevention in case a girl lied about using contraception.

> “First, it will depend on the nature of relationship; either short or long term. Most relationships these days are for sex... safety (protection) is important because you don’t know who is infected with HIV/AIDS and who is not. What is important is...know yourself and the person you are with. I wonder why you should put yourself in the responsibilities that you know you can’t run away from; why would you want to make a lady pregnant and not take care of the child?” (Male, 23y, condom user and partner of pill user, IDI)

Avoiding the burdens of STIs or impregnating a girl was especially important to young men in Kilifi, attributed both to the permissive sexual behavior in coastal locations⁴ and as indicated in the excerpt above, to long-held traditions requiring a man to marry the woman he may have impregnated out of wedlock. Their unmarried female counterparts particularly avoided pregnancy (or another pregnancy) out of wedlock in order to complete college or improve their chances of getting a husband.

> “I decided to take it [in my youth] because as I have told you, I wanted to go to college and if not careful, I may not finish college.” (Female, 32y, injectable user, IDI)

> “I did not want to get pregnant again, especially at home before marriage, because another child would reduce my chances of getting married.” (Female, 20y, pill user, IDI)

Young people in Kilifi also perceived that starting on hormonal contraception in youth (whether in or outside marriage) may in the long-term cause complications and altogether compromise a woman’s fertility due to accumulation of contraceptive hormones in the body. Thus, young persons (unmarried and new in marriage) appeared to rely on the male partner using condoms to avoid pregnancy out of wedlock or for child spacing. Males commonly cited concern for the wellbeing of their female partner (a wife or a girlfriend they intended to marry) and their future dreams of having children as the motivations for using condoms.

> “Just like I had explained to you, if you use contraceptive pills... after some time there are side effects. She [wife] personally told me she would not want to use them because there are side effects mostly at old age. Since I love her I would wish to live with her for long... not visiting the

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⁴ Linked with sex tourism in coastal Kenya
hospital all the time. However, a condom is natural; once you are done with it, it is already history.” (Male, 23y, married condom user/partner of occasional pill user, IDI)

Economic considerations as stimulus for smaller family size desires
Participants also expressed the view that child spacing was interwoven with economic concerns. Overall across the study sites, participants reported desire for smaller families or for child spacing, apparently linked to economic considerations of ability to provide the basic needs.

“I wanted the number of children that I can feed, clothe, and educate, and if they would have been more then that would have been difficult...” (Female, 25y, IUCD user, IDI)

“One should check their health, and then check on their family status, the economy and finances, and what they have planned for their future. Like here in the coast, life is so expensive so you have to plan your family.” (Female, 27y, injectable user, IDI)

However, the above concerns did not necessarily translate to immediate contraceptive uptake, resulting in couples surpassing their targeted number of children, attributable to perceived negative effects of contraception.

“Because at times one uses family planning and experiences problems. Like for me I experienced problems. Initially I wanted three children but got five because I experienced problems and stopped and finally went for tubal ligation.” (Female, 36y, tubal ligation user, FGD)

Partner support and conflicting spousal fertility desires
A fifth of women and men interviewed in Phase II indicated that partner support or communication was an important consideration prior to FP uptake. Most participants indicated that family planning decisions should be made by both partners, citing reasons including mutual respect for their relationship, joint responsibility for current and future children, and to cushion fears about potential undesirable consequences of FP use. A small subset of women indicated that their partner’s lack of support was the primary consideration outweighing their own desire to prevent pregnancy. This resulted in delayed contraceptive uptake, much after they had surpassed their own desired family size.

“I wanted three [children] but with my husband that was impossible because he wanted six. I went for family planning after my third child without his knowledge; he started quarrelling with me after some time because I was not getting pregnant. I stopped [using] family planning and I got pregnant...taking care of children is a real problem because of food and education.” (Female, 35y, injection user, IDI)

3.2 What are participants’ contraceptive knowledge and attitudes?

3.2.1 What are participants’ understandings of contraception?
Participants were asked to share their thoughts about contraception and to list all contraceptive methods they knew of, regardless of whether they were a user or had used any of the listed methods. The findings here are shared in that context.

The concept of family planning was discussed in the terms commonly used for it locally, including Ukubanga Oroiboro or family in Kisii South, and Kupanga Uzazi in Kilifi. The data from interviews with men and women suggested that people across the sites understood these terms to mean “having
children by plan” including 1) starting when one is ready to have children, 2) spacing children to enhance both the health of mother and child, and 3) determining and limiting the number of children to a size one could provide for. Excerpts below from in-depth interviews in Kisii South and Kilifi illustrate these points.

Moderator: When you hear of the word “family” what comes to your mind?
Participant: As for me when I hear what comes to my mind is to plan and space a child so that you can have good health and again so that you do not get another child while the other one is still young. (Female, 35y, non-user, IDI)

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Moderator: When you hear the word kupanga uzazi, what do you think of?
Participant: I think of a situation where you have one child and you take some time before getting another so that you are able to take care of them well… it is spacing between one child and another. (Male, 28y, user, IDI)

3.2.2 What is the balance between pros and cons of contraception?
While people could articulate understanding of the concept of contraception or family planning, the data suggested two views of contraception, illustrated in excerpts from focus group discussions with women in Kisii South and men in Kilifi, below. On one hand, people viewed contraception from a benefits perspective, as a gateway to a good or comfortable family life. For many holding this view, and as alluded to in the preceding section, the main push seemed to come from perceived economic strains of raising a large family, particularly with the continually rising cost of living.

“The cost of raising many children is high. You know we are used to saying that if you have many children then those are signs of wealth but with this lifestyle children are no longer wealth anymore. It can be a big burden and may overwhelm you; the children may even face difficulty in accessing basic needs in life.” (Female, 28y, user, FGD)

On the other hand, there were perceptions that despite their reported benefits, the perceived cons weighed heavily against the pros of contraception. Holders of this view were either informed from personal experience, rumors about the unknowns regarding the potential negative effects of contraceptives, or as indicated in the excerpt below, a mix of perceived social pressure and religious beliefs prohibiting birth limiting.

Moderator: You mentioned capabilities…you mentioned that you can even get two so you have decided to plan. Let us talk about family planning. What is [the] community’s opinion concerning family planning?
Participant 2: You saw us write that we are Christians; it is said in the Bible that we should give birth and fill the world…every child has its blessing…a child is a gift from God. (Male, 33y, non-user, FGD)

Moderator: Aha...
Participant 4: Yes that was what I wanted to add; it is said God wanted us to give birth, and contrary to this is against his command. Sometimes [in the past] we talked differently, but where life is now [economic situation] you cannot give birth to too many children even if we are Christians. But if you limit births it is seen to be against God’s will. Traditions also support this [not limiting births]. (Male, 31y, user, FGD)

Table 8 summarizes the distribution of responses across perceived benefits. Among the women who indicated that fertility control was the main benefit of contraception, three indicated that it was specifically beneficial as a way for women to control pregnancy in situations where fertility desires were incongruent between sexual partners.
Table 8: What are the perceived benefits of contraception?

<table>
<thead>
<tr>
<th></th>
<th>Kilifi ((N=20) n(%)</th>
<th>Kilii South ((N=17) n(%)</th>
<th>Gender ((N=35) n(%))</th>
<th>Gender ((N=36) n(%))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ganze (N=20) n(%)</td>
<td>Mtwapa (N=17) n(%)</td>
<td>Lyabe (N=17) n(%)</td>
<td>Nyamagundo (N=17) n(%)</td>
</tr>
<tr>
<td>Fertility Control</td>
<td>10(50)</td>
<td>7(41)</td>
<td>8(47)</td>
<td>9(53)</td>
</tr>
<tr>
<td>Increase Women’s</td>
<td>2(10)</td>
<td>-</td>
<td>-</td>
<td>1(6)</td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve Spousal</td>
<td>2(10)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: Stop Births</td>
<td>1(5)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(Permanent FP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One woman indicated that she felt the weight of caring for the children fell on the wife and thus she needed to be able to control future pregnancies:

“Life is hard nowadays, the child needs to get education, clothes, and things have become more expensive. So if you get more children it is you who will suffer not even the husband.” (Female, 32y, injectable user, IDI)

Another woman had a similar view and indicated that she was using an injectable contraceptive without the knowledge of her husband:

“I do not want to disagree with my husband...that is why I am on this injection, so that my children will be well grown and I can take care of them.” (Female, 23y, injectable user, IDI)

Finally, two male participants indicated that family planning was useful in improving the quality of sexual relationships, by allowing for increased sexual activity without fear of pregnancy. One woman indicated that she perceived the main benefit of family planning as a permanent way to control fertility.

3.2.3 What contraceptives do participants know of, and what do they know?
In both study phases, women and men listed a range of contraceptive methods they generally knew of (mostly had heard of, if not already seen or used). The most commonly known method was the pill, followed by injection, and then condoms. Implants and IUCD were mentioned but cited as methods about which little was commonly known. The excerpt below from a focus group discussion with women 20–28 years of age (all currently using FP) in Kisii South illustrates these points.

**Moderator:** Tell me what family planning methods are you aware of?
**Participant 5:** Pills.
**Participant 1:** Injections and coil.
**Participant 4:** Sticks. (Laughter across the room) I don’t know what other name they are called by...we call them sticks around here. They are placed on the arms and prevent pregnancies.
Participant 5: There is also female sterilization and natural family planning.

Moderator: Okay is there any other method that we have perhaps left out?

Participant 9: Traditional ones.

Moderator: Okay I want us to discuss each of the methods that you have mentioned at length. Let us start with the pill. Is it a popular method around here? Do women like it a lot as a family planning method?

Participant 9: Most women here prefer using injections and some pills, but pills are not particularly popular. The other methods mentioned we have only heard about them but don’t really know much about them. (Nods of agreement from everyone... then giggles) Pills one can forget to take, for example if one is [traveling].

Participant 5: I have also heard that they [pills] don’t get completely dissolved when swallowed...

Data from Phase II (current users only) seems to validate that users often only knew the method they had tried before or were currently using. Any reporting beyond their tried and/or current method was based on the little they may have learned from providers, if not peers.

Table 9 summarizes what men and women reportedly knew about the different methods, often expressed in terms of perceived method advantages or disadvantages. These perceptions were shared across the study phases among users and non-users of modern contraception. Notably, current users acknowledged similarly with non-users that all methods had their pros and cons. However, unlike non-users, users weighed perceived cons of contraception against those of unintended pregnancies and/or large family sizes, and opting for contraception, looked for the method that best suited their situation and desires. These fears are discussed in detail in the next section.

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Data from across the study sites suggested minimal discussion, if any, about contraception. This was attributed to perceived social norms prohibiting birth limiting in Kilifi, and fear of witchcraft in Kisii South. Contraception was thus a very personal matter; users mostly sought information from service providers. Often, a decided prospective user visited the health service with a preferred method already in mind, and wanting “fast service” lest other people learn the motive of the visit. Service providers in Kilifi confirmed that this left little room to sensitize clients on the full method mix available, let alone offer adequate contraceptive counseling.
Table 9: What methods do individuals know, and what do they know?

<table>
<thead>
<tr>
<th>Method</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pills</td>
<td>CONS: Many side effects, e.g. weight gain (makes women less active), heavy bleeding. Causes women to be too wet (makes man to lose power of his manhood).</td>
<td>PRO: Can be discontinued at any time</td>
</tr>
<tr>
<td></td>
<td>CON: Daily pill burden. Can forget to take.</td>
<td></td>
</tr>
<tr>
<td>Norplant</td>
<td>PROS: Fewer stories of method failure/side effects compared to hormonal pills. Easy to discontinue use when ready to conceive. CON: How method works not well known.</td>
<td>CONS: Cutting (incision) in the arm needed. How method works not well known, though commonly used in Kisii South.</td>
</tr>
<tr>
<td>Injection</td>
<td>PROS: Fewer side effects compared to pills. No risk of forgetting to take compared to pills. CON: Woman becomes cold (no libido).</td>
<td>PROS: Easy to discontinue use when ready to conceive. Recommended among women friends. Choice between short-term (1–6 months) and long-term (5 years). Convenient (no daily pill burden, no risk of forgetting to take). CON: Blocks menstruation (blood trapped in the body may endanger life). Woman loses libido. Can affect/block fertility.</td>
</tr>
<tr>
<td>Condoms</td>
<td>PROS: No hormones, so no side effects (important to unmarried girls, and young couples). Dual protection against STIs and unintended pregnancy (important to unmarried girls and persons in extra-marital relationships). CON: May bring couple distrust. Reduces sexual pleasure. May burst and lose protective benefit. Sometimes not so easily accessible. Embarrassing to collect in public. Embarrassing if misplaced in house and children play with as “balloons.”</td>
<td>PROS: Similar to those perceived by men (see column to the left). CON: May bring couple distrust in each other. The lubricant causes women to itch. May burst and lose protective benefit.</td>
</tr>
<tr>
<td>IUCD/Coil</td>
<td>PROS: No hormones. Can offer discreet use benefits (woman carries it in her). CON: Heavy bleeding in user (makes partner unavailable for sex, may harm user’s health). Hinders sexual enjoyment for men (pokes their manhood). Method of insertion undesirable if health provider is male (particular concern to men in Kisii). Can dislodge during sex and require surgery to remove from woman’s womb.</td>
<td>PROS: No hormones. Can offer discreet use benefits (cited in Kilifi). CON: Compromises a woman’s hygiene (sperms trapped in the coil). Embarrassing method of insertion (major concern to women in Kisii). May dislodge during sex (conception with a deformed fetus). Heavy bleeding (may cause user to get anemic, may cause male partner to seek mistresses/extra-marital affairs). Men complain of threads poking them (lower male libido).</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>PROS: Failsafe method if in chronic illness or if couple had attained fertility desires. CON: No turning back.</td>
<td>PROS: Failsafe method. CON: No turning back (women want to retain fertility in case of marriage breakdown and remarriage, or in Kisii, fear of witchcraft).</td>
</tr>
</tbody>
</table>

3.2.4 What do users know about how their current contraceptive works?

Injectable contraceptive
Although all participants discussing injectable contraceptive (n=20) reflected understanding that it prevented pregnancy, most participants indicated that they did not know how the method worked and had neither asked nor had been provided that information prior to their decision.

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Women recommended the injection as a more convenient method unlike the pill that one could easily forget to take. Also, injection was a method that one could use discreetly. Some women may secretly use contraceptives if their spouses and extended family oppose contraceptive use. Participants in Kisii South reported generally that contraceptive use was a personal matter, especially to avoid falling victim of witchcraft. If it was known that a woman was using contraception, she could be bewitched so that her living children died, and that the woman’s womb never be blessed with children ever after.
Some participants (n=2) indicated that injectable contraceptives served to weaken both eggs and sperm, thereby preventing successful fertilization. Others (n=2) indicated that the injectable mixed with blood in the uterus thereby blocking conception, or that it reduced the lining of the uterus; in the event of pregnancy, the fertilized egg would be unable to stick to the wall and would be aborted.

**Implant**

Similar to the injectable, although all participants (n=20) understood that implants prevented pregnancy, most of them indicated that they did not know how the method worked and had not asked nor been provided that information prior to their decision. Just two participants referenced the release of “medicine” from the implant but were unable to describe how the “medicine” works to prevent pregnancy.

**Combined oral contraceptive pills**

All twenty (20) participants discussing oral contraceptives articulated understanding that they prevented pregnancy. Also, almost all (n=19) indicated knowledge of how the method worked and either asked for or had been provided that information prior to their decision. One female participant indicated that the medicine released from each pill “goes up to the egg that is roaming and wants to be fertilized and makes it weak” but could provide no further details.

**Male condom**

Twenty (20) participants discussing condoms described the method as providing barrier protection between the male and female organs, preventing release of sperms into the vagina. Whether this was based on information provided by communication initiatives or was deduced by personal experience was not clear.

**Intrauterine contraceptive device**

Three of six participants discussing the IUCD indicated that they had no knowledge of how an IUCD prevented pregnancy. One participant indicated that the IUCD damaged or weakened sperm. Two participants suggested the IUCD provided a barrier between the sperm and eggs inside the uterus. As one participant explained:

“They [health workers] said that there is a place where the sperms are supposed to meet the egg and then fertilization takes place, and so the coil is in between that space.” (Female, 25y, IUCD user, IDI)

3.3 What are participants’ contraceptive fears and underlying factors?

3.3.1 What fears and/or misconceptions are associated with contraception in general?

Reported fears about method complications and undesirable effects were many, though not necessarily informed by personal experiences. Notably, these discussions were often marked with the terms “You hear...,” “I was told...,” and “I have heard...”. However, where it applied, participants in interviews in Phase II reported they were sharing actual experiences occasioning method switches. These generalized fears are summarized in Table 10 below in four themes including concerns about 1) potential method complications, 2) undesirable physiological effects, 3) negative social consequences, and 4) potential for contraceptive failure, and by extension, risk of a birth defect. The specific method fears are outlined in Table 11.
### Table 10: Categories of fears generally associated with contraception

<table>
<thead>
<tr>
<th>FEARS</th>
<th>EXAMPLE OF FEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method complications</td>
<td>- Womb growths/wounds</td>
</tr>
<tr>
<td></td>
<td>- Barrenness/infertility</td>
</tr>
<tr>
<td></td>
<td>- Birth defects/deformed children</td>
</tr>
<tr>
<td></td>
<td>- Certain health risks associated with:</td>
</tr>
<tr>
<td></td>
<td>- Method expulsion or shift (implants/UCD)</td>
</tr>
<tr>
<td></td>
<td>- Weight gain</td>
</tr>
<tr>
<td></td>
<td>- Failure to have monthly periods</td>
</tr>
<tr>
<td></td>
<td>- Heavy and prolonged monthly periods</td>
</tr>
<tr>
<td>Physiological effects</td>
<td>- Heavy/prolonged menstruation</td>
</tr>
<tr>
<td></td>
<td>- Occasional reduced ability to perform domestic chores</td>
</tr>
<tr>
<td></td>
<td>- Loss of monthly periods</td>
</tr>
<tr>
<td></td>
<td>- Reduced libido</td>
</tr>
<tr>
<td></td>
<td>- Localized pain</td>
</tr>
<tr>
<td></td>
<td>- Weight gain/loss</td>
</tr>
<tr>
<td>Negative social consequences</td>
<td>- Spousal abandonment in case of method complications</td>
</tr>
<tr>
<td></td>
<td>- Spouse may take another wife to get desired children</td>
</tr>
<tr>
<td></td>
<td>- Spouse may take on a mistress for sexual satisfaction</td>
</tr>
<tr>
<td></td>
<td>- Existing children may get bewitched by evil persons</td>
</tr>
<tr>
<td>Contraceptive failure</td>
<td>- A reciprocal determinism exists between this fear and fears about possible birth defects</td>
</tr>
</tbody>
</table>

#### 3.3.2 What are the commonly perceived method-specific fears/outcomes?
Table 11 outlines the various method specific fears discussed by participants in both study phases, showing fears that are common to several methods. Notably, some of these are based on hearsay as well as real experiences, depending on user status and what methods a user has tried before or is currently using. These are discussed in detail in the next section, limited to Phase II in-depth interviews with current users.
### Table 11: Method-specific concerns

<table>
<thead>
<tr>
<th>METHOD</th>
<th>EXAMPLES CITED</th>
</tr>
</thead>
</table>
| Injection  | - Blocks menstruation; periods stuck in the body endanger life  
- Suppresses production of eggs; may cause barrenness  
- Ceases to be effective with prolonged use  
- Prolonged use may result in birth defects  
- Causes low female libido; may constrain spousal relations |
| Pills      | - May result in birth defects  
- Collects in one spot in the body, causing ovarian cancer/wounds  
- Causes woman to be too wet; men lose manhood power during sex; may constrain spousal relations  
- Incorrect use may result in pregnancy with deformed fetus |
| Implants   | - Heavy bleeding poses health risks, may constrain spousal relations  
- Can disappear in veins if user performs heavy/manual work  
- Weakens section (arm) where inserted, costly in terms of work hours lost  
- Prolonged use may result in deformed babies  
- May cause wounds/cancers of the stomach |
| IUCD       | - Sperms are trapped in the coil; compromises woman’s hygiene  
- May dislodge during sex; may cause pregnancy with deformed fetus  
- Threads prick man during sex/cause him to lose libido; constrain spousal relations  
- Abdominal pains and painful menstruation with a foul smell  
- Embarrassing mode of insertion (main contributor of low uptake)  
- Surgery to remove IUCD is the only way to discontinue use  
- Not recommended for women still with fertility desires |
| Condoms    | - Lubricant decreases male libido, causes stomach ache for women  
- May burst and get stuck in the vagina  
- Users are perceived promiscuous; especially if married |

### 3.3.3 Users’ perceived method-specific advantages, side effects, and fears.

Similar to Phase II, which focused on individual experiences of current users, Phase I in-depth interviews also contained some questions specific to contraceptive use and experience among “ever users” (current or discontinued). Key questions circled around:

- What contraceptive method are you using now/were you using previously?  
- What kinds of challenges or changes have you [or your partner] experienced with this method?

The method-specific challenges highlighted in this section draw from these interviews.

**Injectable contraceptive**

Only 3 of 20 ever users of injectable contraceptives identified potential disadvantages with this method, including the short-term contraceptive gaps between injections, the cost of the injections every 3 months, and the possibility of underskilled personnel (not trained in dispensing injectable contraceptive) offering injection with the wrong dosage.

Participants mentioned a number of potential physiological side effects that they had heard about from others, including increased menstruation, stomach pains and cramping, weight gain or loss, formation of
fibroids, increased blood pressure, and decreased libido. Two participants also mentioned hearing about the possibility of infertility or fetal deformities from long-term use. As one participant explained:

“The fears I had is when I hear someone saying you will give birth to disabled children... children with little abilities... who don’t understand themselves that is [mental disabilities]. So that is something that was making me to stay and fear after a while I decided to use.” (Female, age not disclosed, implant user, IDI)

However, only 9 of the 20 ever users of injectable contraception indicated that they or their partner had suffered from a number of side effects, including dizziness, rapid pulse, overall weakness, amenorrhea or reduced menses, increased and/or painful menses, decreased libido, and increased acne, among others. Excerpts below highlight the perceived problems of amenorrhea, increased menses, and decreased libido, respectively.

“I have fear because she has never received her monthly periods and I wonder where the blood is going to. Is it in the body which will affect her or what?” (Male, 23y, partner of injectable user, IDI)

“Just recently we had gone on a trip outside home for the first time since she gave birth and that is when she experienced her first monthly period recently...it took almost seven days. It really had come in a bad way ... if the blood came when it is watery or normal then it is okay, but if it comes in a bad way it has blood clots, then you’ll know that’s a bad way.” (Male, 27y, partner of injectable user, IDI)

Moderator: Has there been any conflict in your family as a result of using this method?
Participant: Let’s say the time you are making love you feel like you don’t want him to touch you…that is the problem.

Moderator: And before you started using...
Participant: We were very ok, but now... (Female, 28y, injectable user, IDI)

A small number of participants also expressed fears related to using injectable contraception. All three participants mentioned the fear of long-term infertility due to long-term injectable use.

Implant
One of 20 participants ever using an implant mentioned the long-term pain at the point of insertion. Other physiological side effects were listed by two women, including increased menstruation, reduced menstruation or amenorrhea, stomach pains and cramping, weight gain or loss, swelling of legs and decreased libido. Only three women listed a potential for long-term infertility. All these were reportedly based on what they had heard from others.

However, at least half (n=10) of the women ever using implants indicated that they or their partner had suffered from a number of side effects, including amenorrhea or reduced menses, increased and/or painful menstruation, wounds/ulcers in the lower abdomen, weight gain, dizziness, and chest pain.

“I stayed for a while without seeing my periods. I even thought I was pregnant ...” (Female, 31y, implant user, IDI)
“Recently I started feeling my stomach has problems down below the belly button ... there are doctors who come at the shops they do X-ray. I went, paid, they checked my health... they asked me are you using family [planning]... I said yes...they told me, ‘mum, it will be difficult for you to get a child’... [I asked] why... they told me... you are having stomach ulcers.” (Female, 31y, implant user, IDI)

Five (5) women mentioned concerns related to the use of implants, which included complete loss of monthly menstruation (n=1), health problems from heavy periods (n=1) and the inability to conceive after long-term use (n=3). As one participant explained:

“I have heard that when a time comes when she wants to conceive, some women take a very long time before they conceive. It takes long before they come back to maturity. That is my worry. It is said that one can go up to six months to one year before conceiving.” (Male, 34y, partner of implant user, IDI)

**Combined oral contraceptive pills**

None of 20 ever users of contraceptive pills cited any specific disadvantages to the method. Only two women mentioned potential physiological side effects that they had heard about from others, including increased menstruation and dizziness. Two women mentioned the potential for infertility or health problems from continued use.

Additionally, only four women indicated that they or their partner had experienced physiological side effects related to their pill regimen. These included nausea and loss of appetite, lethargy, decreased libido, and weight loss. One woman narrated the potential strain on spousal sexual relations:

“...you just don’t feel interested in sex, even when your husband makes advances, you have no interest because you are never in the mood...unless maybe he forces you...sometimes it is a fight because of the side effects of the pills. He may even think you are having an affair but it’s just that you are not in the mood.” (Female, 21y, pill user, IDI)

However, participants’ discussion seemed to indicate that side effects were not necessarily perceived to be as severe as the consequence of an unintended pregnancy. One participant indicated that previous use of one type of combined oral contraceptive (COC) had led to serious side effects and she had switched to a different COC formulation that had fewer side effects. Another 21-year-old female participant indicated that although she felt nauseated, this was not a significant deterrent to use.

Participant: I was using the pills and they had side effects on me just like the injection, because there are times I completely lose my appetite and don’t feel like eating.

**Moderator: So you just sit with this problem?**

Participant: You know small problems like this I don’t really bother; I get concerned over bigger issues.

Two participants indicated they were worried about their self-efficacy to adhere to the daily pill regimen:

“When I started family planning I was still living with my husband and it was him who suggested we start planning and even though we did not know God’s plan, we should allow the young child to grow up a bit before we have another one. So I started suing [taking] the pills. But they used
to give me problems so I changed to the injection but it affected me and I went back to the pills which my main problem with is that I keep forgetting.” (Female, 26y, pill user, IDI)

Participants also cited the potential for infertility or problems conceiving as well as health problems from long-term use. In two cases participants indicated that they had come to the health clinic to gain additional information on potential impacts of long-term use because no information had been provided when they initiated COC use.

**Male condom**

Nine of 20 who had ever used condoms mentioned their disadvantages, all singularly identifying the possibility of user error resulting in condom breakage or slipping which could lead to unintended pregnancy or STIs.

“While using it, sometimes it bursts because of the friction and then you start doubting yourself, whether it has really worked [whether you achieved protection].” (Male, 22y, condom user, IDI)

At least seven participants also mentioned the potential health risk for women from a condom bursting and getting lost in her womb.

“Condoms, you know this is a rubber, eh... when it bursts, for example it has burst, and you were on intercourse it can...if it tears apart...it goes to the woman's womb, and it can bring a lot of problems in the reproductive system.” (Male, 30y, condom user, IDI)

Six participants mentioned physiological side effects from condom use, based on hearsay. One participant alluded to the loss of sensation to the penis during sexual intercourse while the other five mentioned the possibility of stomach pains or vaginal irritation among their female partners.

Six participants discussed side effects they had experienced from using condoms. Three of the five participants indicated that they had a loss or decrease of sensation during sexual intercourse. Two participants indicated non-sexual side effects. One participant indicated that the pressure from ejaculation was captured on the inside of a condom which apparently caused abdominal pains. The excerpt below from an interview with a 28-year-old male user highlights this perception, as well as information gaps about why a condom should only be used once.

Participant: Yeah, like that condom, sometimes it has some effects, according to me, in my opinion. If you use a condom very much, you get to feel some abdominal pains.

Moderator: You as the man?

Participant: Yeah, there are some abdominal pains. I do not know whether it is the pressure...in the process of pumping, it goes back inside

Moderator: It goes back inside?

Participant: Yes. And what I know about condoms is that you use them for one round only, not two, because if you use them very much, the pressure will go inside and you will suffer quite a lot.

Moderator: Okay.

Participant: You will have abdominal pains.

The sixth participant explained that the friction between the condom and his penis had caused a mild rash.
**Intrauterine contraceptive device**

Of the six ever users of IUCD, five had switched to this method after negative experiences with other methods. Two of the five indicated that they had experienced side effects. A female participant indicated mild pain in her lower abdomen when bending over. She indicated, however, that she was unsure whether this was related to her IUCD. A 28-year-old male participant indicated that both he and his wife felt there was a decrease in sexual pleasure since they took up the IUCD. However, they were giving themselves more time to experience the coil before returning for medical review:

**Moderator:** How does the coil make the sex less enjoyable?

**Participant:** ...because you know when the woman is on the coil she doesn't get her monthly periods as she used to and so she feels nothing ...

**Moderator:** And does your wife also complain of not enjoying the sex?

**Participant:** ...yes, we discussed it and actually she was the first to bring it up, I did not even realize it before she did.

**Moderator:** And have you consulted the doctor about this?

**Participant:** ...that is what we were planning on doing ...

**Moderator:** So for three months you suffered in silence?

**Participant:** ...yes, we assumed that things will change and were giving the coil a chance.

**Moderator:** Ok, but [how] long after getting the coil did you realize these side effects?

**Participant:** Two months after.

**Moderator:** So you then thought it was the coil?

**Participant:** Yes, but we thought we should give it more time before we come and get medical help.

**Tubal ligation**

None of the four participants who had undergone tubal ligation mentioned any disadvantages. However, a 28-year-old female participant indicated experiencing back problems and leg pains since her operation:

**Participant:** When I first did it I had problems with lifting stuff like putting water on the head, but I knew I had not healed well though you can’t rule out the possibility of perhaps another disease is developing. I don’t know, but now from last year, I have experienced back problems that I have treated. If I bend for long I feel sick.

**Moderator:** So is this a long or short term problem?

**Participant:** I can say I developed it from last year in May when I went to fetch water. I got home I couldn’t even walk, went to hospital and was treated. Again in June I felt the same and sought treatment for about two weeks. Again in November last year I couldn’t even sleep, I was treated but I did not heal, they changed the medicine but I still did not get well until I went to a private hospital and was given two injections per day. I feel much better and have not experienced the problem since then, although a few days ago I have started experiencing pain in the legs.

Two participants cited general fears or anxiety. In general discussion about the various contraceptive methods commonly available in Kenya, one participant in Kisii South indicated that members of the community perceived that there might be negative consequences for the children of those that underwent a tubal ligation.

“No, that is a secret and other people are not supposed to know. You know people fear to disclose to other people for the fear that their children will be killed and be left alone [no children] and yet they have used a permanent method. It is a must that they will go to a hospital [health facility] but that will be their secret...to let people think that it is injection, for example, while it is not.” (Male, 32y, partner of injectable user, IDI)
Another participant cited concerns with possible unintended pregnancy:

“They [clinicians] told us that if I eat well and put on weight the tubes may untie and I would still get pregnant. So we live in fear ...But pray to God to help us we don’t get more children. It is why I was advised to go with my husband in case I get pregnant again and he blames me or accuses me of lying to him.” (Female, 32y, tubal ligation user, IDI)

3.3.4 How are fears, negative outcomes, and contraceptive uptake interlinked?

Our analytical review of the data suggests that while individuals were concerned about the physiological manifestations of side effects, it is the negative social consequences of these contraceptive-related fears and misconceptions that appeared to be of more concern (Figure 3). This section describes the interlinkages between these factors in the outcomes for FP uptake among study participants, summarized in Figure 4.

![Figure 3: Perceived outcomes of fears, misconceptions, and side effects](image)

Fear of the potential negative outcomes of method complications appeared to be a major contributor to low contraceptive uptake. Many women not on contraception suggested that as much as spousal objection and fears of complications were key barriers, women’s overriding related concern was more with a negative social outcome—possibly having no one to turn to in the family should complications arise from secret contraceptive use. In effect, women who could not overcome fear of spousal abandonment or neglect in case of method complications may likely opt not to use contraception until such a time that their spouse may agree. Conversely, women may secretly take up contraception with implications for severe social consequences should complications arise, as illustrated in the in-depth interview with a 21-year-old female using an implant:

Participant: The man is the one who starts [couple communication on contraception]. Like me I started; I used to suffer as a woman...I explained to him, but he said no, the time will come, I am not ready...the time will just come. I gave birth...the fourth, the fifth, the sixth, the seventh...I continued till the last one. That is when he agreed.

Moderator: Before the man agrees the women cannot do it secretly?

Participant: Secretly [you could], but the man should not find any fault [complications]; if you start getting problems of the stomach and you tell him and it comes out that you went for family planning, you can have problems with your...
husband. Openness is very good in the family because if you hide then he “murders you” [phrase of speech commonly used across Kenya to mean the perceived offender would be in serious trouble].

Other concerns about potential negative social consequences were linked to the perceived norms about community pressure to have many children and expectations that a woman should always be able to meet the conjugal rights of a husband. Women feared that failure to conceive (especially in a new marriage, or if the marriage had not been blessed with sons) was socially automatically interpreted to mean a man was free to add another wife or chase away his uncooperative wife (especially if she was on contraception) and marry a new one.

“These days if a woman uses these [contraceptive] methods a man will just tell her to continue using, then he will go look for another woman who wants to get a baby immediately. It has caused today’s generation to have two to three wives because of this issue of delaying pregnancy. They will tell them that you have decided to prevent pregnancy then that is ok let me look for another one who will get me a baby and I be called a father. Because am being asked at home why am I not getting a baby? You will find a 23 year old man with two to three wives!”
(Male, 23y, non-user, FGD)

Fears about a man taking on new sexual partners were more commonly cited in Kisii South than Kilifiix; fueled by several concerns including notions that 1) contraceptives reduced a woman’s libido so she would be unresponsive during sex, thus unappealing to her spouse, 2) a method with perceived effects such as heavy bleeding or extended monthly menstruation made her sexually unavailable to her partner, 3) a method perceived to make a woman “over-lubricated” made her sexually undesirable to her partner, and 4) a woman on contraception (wanting to limit births) was going against martial purpose for child bearing. The excerpt below from an in-depth interview with a 35-year-old female discontinued user of injectable contraceptive in Kisii South illustrates the perceived problem of low female libido.

Participant: I will never use again because it became a disadvantage like I told you; maybe it is lunch time and I need to make lunch and I am sleeping. Additionally, maybe your husband wants to have sex with you and you do not have the desire.

Moderator: But there are so many other methods and you told me about the coil, pill, injection, and… (Referring to the notes); you have told me quite a number and there is the implant. You have only tried the injection. Do you think if you your experience could be different with another method?

Participant: I do not think it will be different because I have information and I have read books and I know maybe this one rhymed with my body and that was why I became fat. However, I could say it was because it made me sleep a lot; because even a child who sleeps a lot is always chubbier than one who does not sleep. Again, now I do not need it because we are now in good terms with my husband and we know how we are planning our family the two of us.

Concerns about contraceptive effect on libido were expressed liberally by men and women. While women feared repercussions of not being aroused by their spouses, men had concerns about not enjoying sex with their wives even if the latter were to be sexually available. These were because of perceptions that certain contraceptives made women overly lubricated (too wet) and sometimes smelly, while the IUCD strings reportedly poked the male organ. Also, women’s low libido meant a woman

ix It is possible that women in Kilifi did not register concerns about their spouse taking on additional wives since having more than one wife is culturally acceptable in the region.
would just provide sex without fully being a part of it. These factors resulted in the man himself possibly losing interest in sex with his wife, as alluded to in the verbatim remarks below.

*Before using this method we used to really enjoy sex and feel each other warmly, but things changed after using pills. You will just have sex with her...she is your wife...but you see she becomes so watery to a point of no enjoyment at all, and this even smells very bad.*” (Male, 34y, partner of pill user, FGD)

“But when she has done it [got the injectable contraceptive], even her, she does not have a lot of morale [sexual desire]... (short laugh)... you see, it is your wife, and you want it, if she is hesitant, you will also lose your psyche [desire for her]. Or when you do it, it will not be as it usually is, you see.” (Male, 32y, partner of injectable user, IDI)

Women in Kisii South particularly feared witchcraft, saying that knowledge that one was on contraception could make them a target for witchcraft including bewitching existing children to death so that a couple is rendered childless. In Kilifi, women feared social scorn for being on contraception; a marriage is traditionally supposed to result in children, the more the better. These two fears made open contraceptive talk taboo in the two study sites.

*Now unless you are really close you wouldn’t know. Here, concerning family planning, everybody stays with their problem [any side effects]. You see there is a lot of witchcraft and women fear talking about family planning issues because if other people know and the bad people get wind of the information, they might be bewitched and all their children die...so some of these issues are kept very private.*” (Female, 28y, user, FGD)

Lastly, the fear of birth defects, either as a result of contraceptive failure or compromised fertility following prolonged contraceptive use, and the fear of contraceptive failure seemed to counter-influence each other.

Figure 4 illustrates the effect of individuals’ balance between fears and outcomes (described above) on the initial decision to take up contraception, and decisions for method choice, method switch, and continuation of FP use.

**Figure 4: Fears, misconceptions, side effects, and FP uptake**

3.4 How do current users overcome obstacles/opposition/fear?

In this section we share insights from Phase II targeted interviews with current users of contraception. These interviews suggested an intrinsic motivation to avoid unintended pregnancy in order to have a good life. Thus, contraception was paramount. For the purposes of this report, “obstacles” include
constructs such as certain social barriers affecting accessibility of services, perceived provider skills, and the method in which a specific contraceptive is administered. “Opposition” is used in reference to immediate spousal objection to FP use, and perceived social norms about marriage and children. “Fears” refer to a mix of concerns that arise due to perceptions about contraception in general, perceived side effects and/or complications of specific contraceptives, and related negative social consequences.

3.4.1 Overcoming obstacles

**Self-efficacy and social stigma as inhibitors of access to services**
Availability of contraceptive services is just one aspect of access. Our interviews highlighted the problem related to perceived self-efficacy of potential clients such as young adults and married women to actually use local FP services, compounded by social stigma. Analytical review of the data revealed social stigma in accessibility of services at two levels: 1) young unmarried adults trying to access contraceptives and 2) married women trying to access contraception. Apparently, because of social norms against pre-marital sex, young adults found it particularly difficult to seek contraception, especially through public health services. Furthermore, cost remained a barrier for young adults, so public services offered a ready opportunity for relatively affordable, if not absolutely free contraceptive service. A 29-year-old current user in a Kisii South in-depth interview narrated one popular coping mechanism used by youth, sharing pills, in response to the youth-unfriendly nature of commonly available contraceptive services.

Participant: …you find that when they [young girls] are at the family planning clinic queue they hide themselves…not to be seen on the family planning clinic queue.

**Moderator:** What do they fear that they do not want to be seen to be using family planning?

Participant: The other thing that they fear is that if they are seen on the queue waiting for family planning services and they are seen by women of their villages, the women will start talking how they saw them going for family planning services and that was interpreted that they are promiscuous and sleeping around…because we are preventing ourselves from pregnancy and that is why we prefer not to go for the injection. It is better one person to go for the pill, and she brings it so we share amongst ourselves. *(laughing)*

**Method administration and perceived provider competence**
Obstacles related to administration of a method were in regard to daily pill burden, refill frequency, the insertion method for IUCD, and challenges such as condom bursting.

“The issue of being naked and maybe it is a man putting it [IUCD]; so fear of the issue of someone seeing your private parts.” *(Female, 26y, user, FGD)*

To overcome these obstacles, women simply chose a method that was deemed convenient. In most instances women chose the injection, which was particularly preferred by women desiring discreet use of contraceptives.

“Because with the method of pills, one can forget swallowing, but for the injection it is once every three months so many mothers are used to the injection method than the one for pills, yeah.” *(Female, 32y, injectable user, FGD)*

The perceived competence of the provider in terms of the skill to administer certain FP methods was also a noted obstacle, influencing user decision to only want certain methods and not others. Informants
were more likely to avoid contraceptive methods whose administration entailed invasive procedures while others decided to return home to rethink their decision to take up contraception.

“…so the first one [implant] I saw being inserted with my own eyes, I saw had bled too much and I had also gone to be inserted that one. She wasn’t being inserted by the people from the service provider that I expected, and me, I had already signed somewhere to be inserted, but when I saw how that one had been inserted I just got out and went home…I just left and I had already signed waiting for that one to be served, but when I saw that I said NO.” (Female, 27y, implant user, IDI)

Information and communication barriers
As discussed in the preceding pages, social stigma against birth limiting and fear of negative health and social outcomes made it difficult to seek information and sometimes led to total avoidance of discussing contraception. Notably, women in Kisii South particularly feared witchcraft. In Kilifi, women feared social scorn for using contraception; a marriage is traditionally supposed to result in children, the more the better.

“I did not get anyone to talk to about that... you know family planning is your secret because if you tell anyone what you are doing, if the person is not good, your children will suffer, so it becomes your secret.” (Female, 35y, implant user, IDI)

A 23-year-old non-user in Kilifi explained the social dilemma;

Participant: You know I have not asked them [other women in the community], because when you ask, they tell you that you want to use a method and yet you don’t know if you will ever get a child. So you cannot ask many questions, you just keep quiet and listen [as they talk].
Moderator: So if one does not have a child, it is not easy to find them using a method?
Participant: Here, you cannot be allowed to use because you will be told that you are causing yourself illness.

A common coping mechanism used by women was to only consult with their peers whom they knew may be on contraception, though the final decision for contraception became a private matter, discussed only between the potential user and the service provider. While the latter may sound good, some women reportedly presented themselves at the health service with predefined ideas and method choices, usually wanting “fast service” lest other people learn why she made the visit. The implication is that such users may not learn enough about how the method works and what signs to look out for, or altogether insist on a method not medically suited to them. This in turn may result in continually passing on contraceptive misinformation through informal social networks.

“Women in the community talk and say, today we will go for family planning... your fellow women will tell you ‘myself, I am using injection’... the other one will go for injection and insist to the doctor that she wants injection... when the doctor tries to explain, she ignores.” (Female, 34y, user, FGD)

3.4.2 Overcoming opposition
Opposition was mainly discussed at the interpersonal level involving spouses, in terms of social pressure to have children and spousal fertility desires, particularly for male children to “complete the marriage.” Notably, male and female partners could fall on either side of the divide; while men more commonly opposed contraception, some women reported being against contraception.
Women’s opposition to contraception may be viewed from two perspectives. Often a young unmarried girl or woman in a new marriage may oppose contraception because of the fear of compromising fertility early in life. In such situations, the male partner took the responsibility by using a condom. This was common in Kilifi. In other cases, a married woman may oppose contraception more if the idea was generated by the spouse. In these instances, a woman reportedly did not trust the intentions of her spouse. The excerpt below from an interview with a 32-year-old male user of injectable contraceptive in Kilifi illustrates the gradual process of spousal negotiation initiated by a husband and secretly eliciting the help of the health service to convince his wife to take up contraception.

Participant: Because at first my partner wouldn’t listen. She would ask ‘why would you want to bring these issues of family planning, because if it is giving birth [having children since this is what is expected in a marriage] we are, but why should we start family planning? We should just give birth to all the children we are able to give birth to!’

Moderator: Aha….

Participant: So up to that extent, when I smell that we are about to quarrel over the same, then I suspend the discussion up to the next day.

Moderator: Aha….

Participant: So after some time she finally understood why I was emphasizing; because it is a must we have a family that we can take care of. So the slow speed we took educating each other and making the decision to use family planning was not easy. At times I had to use the doctors and tell them that someone was coming and they should counsel her on family planning, then I would invite my wife without her knowing that I had already briefed the doctors of what to talk to her about concerning family planning.

Moderator: Okay….

Participant: So it is like a clash between Harambee Stars [Kenya’s national soccer team] and she’s hit from all directions both by doctors from the hospital and I at home, and we later came to a decision that I personally wanted.

The two excerpts below suggest that sometimes the matter was not negotiable. A man or woman already decided on taking up contraception ensured the desire was attained, with or without mutual agreement of the couple.

“The first time I mentioned it [contraception] to her, she was not for [it], but later I brought her to the hospital and the nurses talked to us until she accepted. When we set the date, I told her the time has come. She did not go and that day passed. We waited until the next date and I personally brought her. She was operated and later we went home.” (Male, 32y, partner of tubal ligation user, IDI)

“When I talked to my husband about getting an injection he refused and asked me what the injection was for, and I tried to explain that it was going to help in spacing children so that by the time one is in nursery school, we can then have another one, but he said no. So one day I asked him for money to go to the hospital and while I was there I decided to get the injection and told myself whatever happens between us happens, if he wants to chase me then fine. When I got back he looked at the hospital booklet and asked me why I went to get that injection and I told him that I had to even if it meant us separating. Because life is hard enough as it is and I had even thought of getting a tubal ligation and just remain with the three children because if I cannot take care of them what would I do. And he kept quiet but every time I have a return date, he said ‘don’t go, go for the next one’ and he cannot make me to change methods…” (Female, 23y, injectable user, IDI)
Women first appealed to their partners about the economic strains of raising children born closely together or of many children. If partner support was not forthcoming, women typically dealt with opposition from spouses in two ways. Some women took up contraception without hiding the fact (as indicated in the excerpt immediately above), while some women opted to secretly use contraceptives, as illustrated below.

“No, because you can tell a man that the number of children that she has is becoming large and it will be hard for her to maintain them with the hard economic times and he will tell you “do you want my manhood to go down?” (laughter) So a lot of women go for family planning secretly not the way that you explain to us that if you want to go for family planning you go with your husband. You just get it is the women alone that go and explain to the doctor and he gives her a method, but not the husband and the wife going to the clinic together.” (Female, 35y, injectable user, IDI)

Women opting for discreet use of contraception tried to choose methods presumably with fewer negative effects to be able to continue secretly using contraception, but also to avoid conflict in case of negative contraceptive outcomes.

“Mostly, because we do not let our husbands know, we choose the method that has few negative effects so that the husband does not know.” (Female, 34y, tubal ligation user, IDI)

The verbatim quote below from a 29-year-old female user of injectable contraception highlights the potential problem with secret contraceptive use. Despite medical advice, a woman may take a method not medically suited to her, with potentially serious health consequences as well as furthering social misconceptions about contraceptive use.

Participant: And in some families when you are already married and your husband does not agree that you use family planning methods you will take contraceptives secretly and mostly, like where I come from, there is a woman who has not stayed there for long and she has two kids. She was using the injection and she was told that it did not rhyme with her body but she continued using without the knowledge of the husband. Right now as we speak she cannot do any work because of her back… she was discharged just the other day from hospital. She cannot do any work or even sit and she was told to stop using the injections.

Moderator: Who told her not to use?
Participant: The doctor. She was told that the injection was not good for her but she was saying that she did not want to get pregnant.

Moderator: And did the husband know that she was using the injection?
Participant: Yes. He took her to hospital and he was told that it was the injection that was making the wife like that and she should stop using it. She doesn’t want to stop using the injection and the husband wanted her to stop completely because she was getting problems with her back and she cannot do any work… but she does not want to stop because she will get pregnant.

3.4.3 Overcoming fears
Discussions of fears revolved around the question of hormones and the potential negative outcomes of any given contraceptive on one’s health and fertility, and the impact on normal functioning including possible estrangement of couples due to interference with conjugal relations or child-bearing desires. A common trait among most current users was the importance of spousal communication and agreement on contraception and the specific contraceptive method to use, depending on whether the aim is to space or limit births. A female or male partner initiating an FP discussion appealed to her/his partner
citing economic, health, and other benefits of FP use, depending on what s/he felt was most salient to the partner or couple. This discussion enhanced joint decisions about a method or method switching and partner communication if serious side effects arose, averting possible strain on the relationship or abandonment. Notably, partners appeared attracted to methods with minimal side effects as well as those not disruptive to normal functioning, as illustrated from an interview with a female user of IUCD:

“...because as the doctor said, it didn’t have any chemicals and I also explained the same thing to my husband. He also preferred it because it has no chemicals and that I would actually be able to go back to my old self...” (Female, 28y, IUCD user, IDI)

Admitting that all methods potentially had side effects, determined current users weighed their contraceptive options on a case-by-case basis. While social talk about a given method may inform their initial method choices, the choice may change upon consultation with the health service for appropriate advice. Subsequent to this, decisions to stay on a specific method or to switch to another method was weighed on an individual’s perceived self-efficacy to adhere with a method, or actual careful observation of personal experiences with a chosen method.

“On my side, I can look at the side effects the method has. All methods have side effects but you can settle for the one with fewer effects, which people do not complain about a lot.” (Female, 32y, implant user)

“We were told the pill is so bad it has batteries like those in a wrist watch, so I thought that it can go and heap in my stomach. I told my friend we go for the injection and she said that for the injection you cannot forget. The pill you can forget and get a deformed child. They also told me a woman in our village used the pills and they went and formed a wound in the stomach so she went to hospital and they washed her womb but she later died...I decided that the pill is bad. In the market there are people who announce that family planning methods are bad. I then decided to use the injection because I had not heard so many negative things about it. After the injection I started bleeding... I thought this can cause me to be anemic so I stopped using it. So I went for the pills and first I put a pill in water but it all dissolved and I did not see a battery inside...from that day I usually chew the pills to look for the battery. When I find the battery then I will stop using so I have chewed all.” (Female, 30y, pill user, IDI)

Apart from instituting personal coping measures, current users also suggested that method choice should be made from an informed point. It was also noted that it is important to return to the health service to have concerns properly addressed.

“I always see it important that before you start using a certain method, you seek information about them. You get some education too, knowing that if you use this method then you have these advantages or if I do this then these are the side effects. So it is very important and advisable you get educated more on these methods early before you use them...” (Male, 34y, partner of injectable user, IDI)

“...when I had my first injection, I used to bleed and I had back pains, but I went back to the nurse and she gave medicine...” (Female, 20y, injectable user, IDI)
3.5 What are the desirable method characteristics?

Contraception in general was deemed good and as the gateway to achieving life goals, particularly with the rising cost of living. Contraceptive goals and the fit of a method with those goals were interlinked in opinions about method desirability. Table 12 outlines these concepts which are discussed in detail by method in the next section.

Table 12: Method decisions and desirable method characteristics

<table>
<thead>
<tr>
<th>Contraception</th>
<th>Weighing desirability</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>General contraceptive appeal</td>
<td></td>
<td>Must be effective in preventing unintended conception</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Must fit the nature of relationship, fertility desires, and life goals</td>
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<tr>
<td></td>
<td></td>
<td>Stable marriage: Attain fertility desires within financial capability</td>
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<tr>
<td></td>
<td></td>
<td>Shaky marriage: Limit births if suspect male partner infidelity</td>
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<tr>
<td></td>
<td></td>
<td>Unmarried: Avoid new/additional births so as to get a husband</td>
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<tr>
<td></td>
<td></td>
<td>Young: Avoid compromising fertility with hormonal methods (condom users)</td>
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<tr>
<td>Method specific appeal</td>
<td>Perceived effectiveness</td>
<td>Reported low/nil method failure in social circles</td>
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<tr>
<td></td>
<td>Perceived side effects</td>
<td>Dual protection benefit (condom users only)</td>
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<tr>
<td></td>
<td></td>
<td>Minimal side effects</td>
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<tr>
<td></td>
<td></td>
<td>Any side effects not to cause health problems</td>
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<tr>
<td></td>
<td>Cost</td>
<td>Method affordability and implications for continuity of use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minimal refill frequency</td>
</tr>
<tr>
<td></td>
<td>Convenience</td>
<td>Minimal constrain on conjugal relations</td>
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<tr>
<td></td>
<td></td>
<td>Flexibility to interrupt use/switch as needed</td>
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<tr>
<td></td>
<td></td>
<td>Method of administration must not be embarrassing</td>
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<td></td>
<td></td>
<td>Private/discreet – avoid social scorn (Kilifi); avoid witchcraft (Kisii);</td>
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<tr>
<td></td>
<td></td>
<td>take control where husband opposes</td>
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<tr>
<td></td>
<td></td>
<td>Minimal interruption of daily chores (link with side effects; refill frequency)</td>
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<tr>
<td></td>
<td></td>
<td>Minimal risk of forgetting to take (reduced adherence problems)</td>
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</tbody>
</table>

Informants spoke of the desire to have the number of children they could provide for—feed, clothe, educate, nurse, provide better health care—and allowing the parents the time and space to engage in economic activities.

“Family planning is good as it helps in spacing of children and this gives the couple more time to concentrate on other things like investing or your business.” (Unmarried female, 20y, non-user, FGD)

Some informants’ contraceptive uptake was reportedly triggered by the struggles and challenges that their neighbors with larger families faced; thus, the desired method needed to perform its specific function, including simply not failing, enabling birth spacing, or completely stopping more births. The perceived nature of the relationship also influenced couples and/or women’s decisions about which method to use and when, as well as perceptions of contraceptive appeal. Women in presumably shaky relationships appeared to take up contraception to help them limit births in case of abandonment.
“When I first started, I already had my first child and so I decided that I should plan because men are very unpredictable... you might assume you have a life together but you don’t know what will happen in the future as they may just move on with someone else. So I decided that it is not wise to have children every year and then end up taking care of the children alone.” (Female, 31y, injectable user, IDI)

Young unmarried people reportedly wanted to enjoy sex without the burdens that came with unintended pregnancy. Perceptions that an early start on hormonal contraception may compromise future life goals (e.g., getting married) and fertility desires influenced newly married couples to tend to rely on the male partner using a condom.

“Now, it is both, because having a child outside marriage, and I am not ready to become a father, I would want to have a child after I have gotten married.” (Unmarried male, 22y, condom user, IDI)

Perceptions about method effectiveness and side effects, initially informed by social talk, influenced choice of a method in any first instance of use of specific methods. Thereafter, successful users’ decisions for method continuation or switch were based on a mix of their own experiences and consultations with providers either at an FP decision-making point, or on follow-up visits. If the method fitted their needs and the side effects were perceived as minimal, it remained a choice method; otherwise the solution was to switch methods as needed, rather than discontinue contraceptive use.

“…Like I told you, I had side effects. I would not get periods until I stopped the injection. For example I would get my periods after the three months for the three monthly injections and when they would come, the flow would be so heavy I would faint. So I decided to stop and use the pills but if they also affect me I will stop, I will just keep changing.” (Female, 21y, pill user, IDI)

Method convenience, including ease of administration, required refill frequency, and propensity for discreet use, were very important.

“You see if I decide [let us suppose that I were to decide] to use a family planning method without my husband’s knowledge... you know if I go with the pills to the house he will just catch me using it. I will therefore decide to go for injection than this one of pills because he can catch me by finding where I will have hidden and get to know that I am using a family planning method.” (Female, 26y, user, FGD)

While IUCD was perceived to have minimal or no hormones, its mode of administration was embarrassing, making it most undesirable. The daily burden of swallowing contraceptive pills and the perceived propensity for poor adherence resulting in unintended pregnancy and birth defects were a hindrance to the uptake of the daily pill.

3.5.1 What are current users’ desirable experiences with previous/current contraceptive methods?

Injection contraceptive

What makes the injectable desirable?
Twenty (20) participants discussed the reasons for selecting an injectable contraceptive method, centering on previous experience or known side effects of other methods, including:

- Menstrual or other side effects due to COC usage (i.e., nausea, headaches, weight gain, and mood swings)
- Irritation from lubricant used in condoms
- Adverse events with IUCD, including expulsion and loss of fertility

In some cases (n=3) participant information about other methods was based on misconceptions that they had heard from others. As one participant explained, she decided to use an injectable contraceptive after hearing that COC use could lead to infertility:

“There are people who come to the market and they talk about pills. They say pills contain some small metals and they don’t dissolve in the stomach, so the more you continue taking they fill the womb and then you will not have children so they prefer using the injection than the pill, so I went for the injection.” (Female, 20y, injectable user, IDI)

Others (n=3) mentioned positive recommendations they had received from current or previous users of injectable contraception:

“I had spoken to this woman who told me that she was using the three month injection and it was working so well for her and that in three years she had not conceived and was feeling very ok and so I used her experience to guide my choice and that is why I decided to use it.” (Female, 23y, injectable user, IDI)

Additionally, eight participants indicated that injectable contraceptives were not reliant on daily adherence and thus provided fewer opportunities for user error or gaps in protection, as compared with other FP methods such as condoms, COCs, and natural planning. As one male participant explained:

“In short it is my wife who came up with the idea and told me, depending on this method [condom], especially we the mijikenda, we are always tipsy. So when you have your wife at times when she is not safe, you at times decide to have it that way [without using a condom], so it made her decide to use injections.” (Male, 34y, partner of injectable user, IDI)

One participant indicated that she had originally desired a different FP method, but was compelled by circumstances to try an injectable method because her preferred method was out of stock at her nearest local health center:

“I had wanted the Norplant but at that time when I visited the clinic they had run out so they said I could choose the three month injection or the pill, so I chose the three month injection.” (Female, 31y, injectable user, IDI)

Finally, two married men mentioned that they had settled on injectables because they were more acceptable to their partners, unlike condoms which carry connotations of infidelity.

“First of all, if she was used to us having sex with it [condom] she wouldn’t mind. Otherwise, the moment she sees you with it she thinks you had gone to use it with other women. The only way to manage such people is to carry the whole box home and then explain that you had attended a certain seminar where you were given.” (Male, 34y, partner of injectable user, IDI)
Participants cited two reasons for their desire to continue using injectable contraception: 1) the absence of side effects or non-severity of the side effects, and 2) the long-term efficacy as a contraceptive option. As one participant explained:

“It is because I haven’t seen any side effects, so I don’t want to mix them [using one contraceptive method after the other] since later it might bring a problem. If I happen to encounter a problem, then I can want to try another method, but as for now I haven’t seen any issue.” (Male, 34y, partner of injectable user, IDI)

Would they recommend the injectable to others?
Current users of injectables almost universally indicated that they would recommend it to their friends by sharing the benefits of family planning and dispelling misconceptions about side effects by sharing their experiences. One woman provided a recent experience as an example:

“They [friends] have actually asked me and I tell them that this injection is very good but then they say that they have heard that when you get the injection, later on you get abnormal children. But I tell them that kind of outcome is God’s plan…I would tell them to use it [injectable contraceptive]...the injection will make them healthy, their children would get better attention and will dress better. I would tell them it is because if you have like a three-year-old child it would prevent you from getting another who would need so much attention. So now all your focus can be on educating your children and clothing them.” (Female, 23y, injectable user, IDI)

Some participants (n=9), mostly men, indicated that they would be willing to tell others about their experience with injectables but indicated that they did not feel that they could recommend one FP option to another person and would suggest going to a trained health provider. One man in Kilifi explained:

“Right now I can say I haven’t seen any problems, therefore I can tell them to agree with the wife (if it is to come at the health center here) to enquire more....at this health center I don’t think you can tell them to give you an injection and they are willing to do that, I think you have to be given some information then you can therefore choose, if you will use injections or pills. I think if I explained to him or her that way, then they can get more information from this place.” (Male, 34y, partner of injectable user, IDI)

The importance of seeking advice from health personnel was underscored by other participants who added either that a medical examination was needed to determine the right method for every individual, or that they feared anger or retribution from friends or community members should they suggest a contraceptive method which led to adverse events:

“The first thing I would tell them is that the injection is good. But before using it, one should go to the experts. Go to any health facility; let them explain to you, they examine you, if possible. My wife told me that they are usually examined before it is administered...you are the way you are [everyone is different].” (Male, 32y, partner of injectable user, IDI)

“Why I cannot tell them? Because if I tell them and they use it and it has negative effects, they will say I am the one who told them, and again, I am not a doctor.” (Male, 30y, partner of injectable user, IDI)
Implant

What makes the implant desirable?
Similarly to the conversations around injectable contraceptives, 20 participant’s discussion about the reasons for selecting an implant as an FP method centered on previous experience or known side effects of other methods, including:

- Menstrual or other side effects due to COC usage (i.e., nausea, headaches, weight gain, and mood changes)
- Irritation from condom lubrication
- Adverse events with IUD, including expulsion and infertility

As one participant explained:

“I prefer this [implant] because it has few side effects and they are also minor. I asked for opinions before going for family planning and people complain of bleeding, headache, backache, and for pills is the same and injection too.” (Female, 32y, implant user, IDI)

Similar to the injectable, participants indicated that implants were not reliant on daily adherence and thus had minimal potential for user error or gaps in protection, as compared with other FP methods such as condoms, COCs, and natural planning. Three participants indicated that implants were longer lasting than injectables and were the most cost-efficient method given their longevity. As one male participant explained:

“We chose the implant because unlike the depo [injectable] whereby the woman has to come back for the injection after three months, the implants function for two to three years. I was even told there is another one that can last up to five years, so we decided on the implant and madam was not for the idea of taking the pills every morning. So that is how we decided on the implant.” (Male, 34y, partner of implant user, IDI)

Only seven participants discussed specific reasons for continuing to using an implant as their FP method. Four participants cited the need for family planning in conjunction with the lack of side effects or non-severity of the side effects. As one woman who had reported menstrual and other side effects explained:

“You know even if there is a problem you persevere so that you can prevent yourself from getting so many children. Children are the problem I fear...children’s needs are so many even the five [that I have] I stress a lot because of their needs... and my husband is not able and I am not working... I go for casual jobs or I rent a farm and do farming because we do not have land.” (Female, 32y, implant user, IDI)

Two participants cited the long-term efficacy of implants as the main reason for continuation of the method. One of these women indicated that she would like to find an even longer lasting implant.

Would they recommend implants to others?
Similar to users of injectables, most implant users indicated that they would recommend implants to their friends by sharing the benefits of family planning, and highlighting the possibility of negative side effects with other methods. As one female participant explained:
“There are advantages, because if you use the implant there are no effects and the pills are bad because everyone complains about the pills—some complain of dizziness, backaches, but the implants, there are no such complaints.” (Female, 32y, implant user, IDI)

Three male participants indicated that they did not feel that they could recommend one FP option to another person and would suggest going to a trained health provider. As one participant explained:

“I can advise him to go and get information about all family planning methods and then he can decide on his own which method he would like to use because I am not an expert... so I cannot recommend any specific method. I can only refer him to the health experts so that he can get the right information.” (Male, 34y, partner of implant user, IDI)

Additionally, two participants indicated that although they could recommend the implant they underscored the importance of partner consultation and medical advice. This was particularly because they did not feel that they would be able to provide information given their limited knowledge of how the method works.

**Combined oral contraceptive pills**

**What makes contraceptive pills desirable?**

Twenty participants’ discussion about the reasons for selecting COCs centered on known side effects of other methods such as nausea, headaches, weight gain, and menstrual changes.

Five participants mentioned negative experience with other contraceptive methods, mainly injectables, as the impetus to begin a COC regimen.

“You cannot expect someone to bleed every day of their lives [as with injectable contraceptive]; you don’t know how many pads you will use, or when you will need a pad because you have no idea how much you will bleed and cannot afford going to work unprotected. But with the pills you know on a certain day you will get your periods for maybe two or three days, so you know how many pads you will need....things like that.” (Female, 24y, pill user, IDI)

Additionally, two participants indicated interest in COC regimens due to the availability of different brands of pills. As one male participant explained regarding his partner:

“She decided to use pills and it is not just all the pills because there are other pills which she used, I think they are Femi-plan; they made her have a greater appetite so we stopped using them and decide to use some green ones from the government. Those ones (from the government) have helped a lot. She does not have any hormonal imbalance and cravings for food.” (Male, 30y, partner of pill user, IDI)

One participant indicated that her husband had preferred a different FP method, but she was compelled to take COC due to the availability at local health centers:

“He [husband] wanted the five years injection. We went to the doctor but this option was not available at the moment. I was told to choose between the three months injection and daily pills, and I chose the daily pill...” (Female, 30y, pill user, IDI)
Only six participants responded on the question about their reasons for continuing to use a COC regimen. Three of the women cited lack of side effects from COC use or the potential for side effects from other FP methods. Three women did not indicate specific reasons for continuing to use COC other than the need for a family planning method:

“Nothing attracted me, I just tried. If it was not good I could change to another, or I go and be tested first so that I can choose... so I decided to choose the pill. It is better though if I swallow I get nauseated but it is the one that I am using now.” (Female, 35y, pill user, IDI)

**Would they recommend contraceptive pills to others?**
Most participants (n=9) indicated that they did not feel that they could recommend one FP option to another person and would suggest going to a trained health provider. One of these women also reiterated the fear of anger or retribution that could arise from offering FP advice lest she be perceived by the other woman’s spouse as interfering in a family matter:

“No; they better go to the doctor and get all. I cannot advice anybody on that. I do not want somebody to blame me that I told his wife to take family planning. When I wanted, I went to the doctor for advice. So the wife and husband should go and get from the doctor.” (Female, 30y, previously on injectable and now a pill user, IDI)

Some participants (n=4) indicated that they would recommend pills to their friends by sharing the benefits of family planning, and highlighting the possibility of negative side effects with other methods or with different COC formulations, and the subsequent need to make personal observations and judgment for when a method switch may be needed. As one female participant explained:

“I would tell my friend to try…and tell them I preferred My Choice [COC brand name] but there are others who use Femi-plan [COC brand name] and they suffer no side effects. So I would tell them if they want to start there is Femi-plan and then there is My Choice and if they suffer any side effects they should change.” (Female, 26y, pill user, IDI)

Additionally, two men indicated that they would recommend COCs to their friends due to the fewer side effects as well as the acceptability of these methods by their partners, as compared to condoms in particular:

“In a faithful marriage, condoms are not good. Many of those I have talked to don’t like injections and also Norplant. Even before I got married most of those I had [women friends] felt that they were not good, so personally I would go for the pills...Trust is a very important thing in any relationship be it a marriage or any relation. In this case being in a marriage and all of a sudden your partner tells you to start using a condom! Then personally it would suggest to me that this person is not being faithful. Or they feel I am not faithful to them.” (Male, 30y, partner of pill user, IDI)

**Condom**

**What makes condoms desirable?**
Nine of 20 participants discussing condom use indicated that they had selected condoms due to their dual protection advantage, i.e. preventing both pregnancy and STIs:
"It is just like I said... it offers dual protection against diseases and pregnancy. Because these other methods according to what I know, they only prevent pregnancy." (Male, 22y, condom user, IDI)

Five of the nine participants added that condoms are a “temporary” method of family planning and are useful for unmarried individuals who might have multiple sexual partners or want to prevent pregnancy. As one 25-year-old unmarried male participant explained:

Participant: If I don’t use a condom, she will get pregnant or a diseases. So until we get married. We will use a condom then after now we can decide on what to use if it’s injection or the pills.

Moderator: Apart from your fiancée in college, do you have any other partner... Who you are having sex with?
Participant: That is a must. (laughing) A man is a man. You know feelings can come any time.

Moderator: So that is why you decided to use a condom, to stop the spread of diseases from one person to another?
Participant: Yes.

Five of the nine participants added that condoms are a “temporary” method of family planning and are useful for unmarried individuals who might have multiple sexual partners or want to prevent pregnancy. As one 25-year-old unmarried male participant explained:

Participant: If I don’t use a condom, she will get pregnant or a diseases. So until we get married. We will use a condom then after now we can decide on what to use if it’s injection or the pills.

Moderator: Apart from your fiancée in college, do you have any other partner... Who you are having sex with?
Participant: That is a must. (laughing) A man is a man. You know feelings can come any time.

Moderator: So that is why you decided to use a condom, to stop the spread of diseases from one person to another?
Participant: Yes.

Moderator: Apart from your fiancée in college, do you have any other partner... Who you are having sex with?
Participant: That is a must. (laughing) A man is a man. You know feelings can come any time.

Moderator: So that is why you decided to use a condom, to stop the spread of diseases from one person to another?
Participant: Yes.

Five participants indicated that they had chosen condoms due to their low cost—often offered free of charge at health clinics—as well as their widespread access. Four participants indicated that they had decided to use condoms due to the lack of side effects, as compared with other methods. As one married male participant explained:

“Just like I had explained to you, if you use Femi-plan pills there are those side effects... after some time there are side effects. She personally told me, she wouldn’t want to use them because there were side effects mostly at old age and being in love with her I would wish to stay with her for long but not visiting the hospital all the time, but a condom is natural, once you are done with it it’s already history.” (Male, 23y, condom user, IDI)

One participant indicated that he had chosen condoms due to the ability to have single sex-event protection. He explained that he and his partner usually used a calendar method but used condoms to supplement this method on days they deemed as “unsafe.”

Three of four participants responding to the question about the reason for continuing to use condoms as a family planning method indicated that they would only continue to use condoms until they were married. One unmarried man explained that he would continue to use condoms because they allowed him control over his protection in contrast to female-controlled methods. As he explained:

“The reasons are as I had explained to you, its safety depends on me personally, and if I say I will not use it then I would be risking my own life and that would haunt me for I will know that I did not use it. It cannot be compared to taking pills where someone can tell you that she will take the pills and maybe later fail... you can’t keep watching them every minute whether they have taken or not.” (Male, 23y, condom user, IDI)

Would they recommend condoms to others?
Fifteen of 17 men who reported currently using condoms indicated that they would recommend them to their friends. Participants indicated that they would highlight a number of benefits to condom use, including dual protection from STIs and pregnancy, availability and low cost, ability to individually control use, ease of use and lack of side effects to partner. The remaining two current condom users
indicated that they did not feel that they could recommend one FP option to another person and would suggest going to a trained health provider.

**Intrauterine contraceptive device**

**What is desirable about the IUCD?**

Five of six participants who were currently using an IUCD indicated that they had switched to the coil after a negative experience with other FP methods, while one mentioned convenience and concerns about hormones.

“I was using pills but then my husband moved to Nairobi and I stopped using them because I was using them when he was here. After our second baby I thought with a second baby I would rather get an injection. The injections would be three monthly instead of taking all those pills but he was still in Nairobi so getting injections while he was in Nairobi, I just felt that using all these drugs while he is away was not a good idea. So I talked to the doctor and he said that if I felt that I had used drugs for so long then maybe I should consider the coil because even if he is not there, that is just something that is inserted and all you have to do is take care of it.” (Female, 25y, IUCD user, IDI)

One participant cited the minimal side effects and discreetness of IUCD.

“My wife went to the facility, then she was advised about the coil and then I was also called in and we consulted with the doctor and we both thought it was a good idea [no side effects]. Plus it spares you embarrassment unlike the condom which people see you picking from the facility ....” (Male, 28y, partner of IUCD user, IDI)

**Would they recommend the IUCD to others?**

All six participants indicated that they would recommend the IUCD to family or friends. Most participants (n=4) indicated they would cite the lack of side effects.

One participant indicated that she would generally recommend the IUCD but would ensure she addressed fears about insertion. As she explained:

“I have told many, there are some who tell me they have gone for family planning and the injection is not good. I have tried to tell many but some women are afraid because of hands being put in their vagina; they are afraid so they stay at home.” (Female, 34y, IUCD user, IDI)

Another participant emphasized the discreetness of the IUCD.

“I would recommend because I feel that it is less embarrassing because once the coil is inserted she will walk around with it unlike the condoms, which if misplaced will cause you embarrassment if the children come across them and start playing around with them...” (Male, 28y, partner of IUCD user, IDI)

**Tubal ligation**

**What makes tubal ligation desirable?**
All of the four participants who indicated they or their wife had undergone a tubal ligation suggested that they had decided on this method due to desire to have permanent contraception.

Two participants indicated that they decided to undergo tubal ligation following adherence problems with a previous contraceptive method, which led to an unintended pregnancy. As one participant explained:

“I continued using pills and then later I forgot to take the pills. I had decided to stay with the two children but I conceived and gave birth to twins and decided to change the method and went for the blocking.” (Female, 34y, tubal ligation user, IDI)

Would they recommend tubal ligation to others?
All four participants indicated that they would recommend tubal ligation as a way to achieve a permanent solution to birth limiting. Participants indicated that they would feel comfortable recommending tubal ligation because of the positive effects on a woman’s health as well as the ability to focus on economic sustainability for the household, as illustrated in this excerpt from an in-depth interview with a 32-year-old male.

Participant: I can tell her/him about family planning: a child to get good life, quality education, and also give your children time; giving birth without spacing can bring problems even in school fees. Others ask and we tell them.

Moderator: What can you tell the friend regarding this method that you are currently using?
Participant: I can tell them because when the wife gives birth so much, she becomes weak and worn out and the constant breastfeeding makes one have inadequate blood.
CHAPTER 4: COMMUNICATION AND PARTNER CONSULTATIONS

4.1 Overall take on communication and consultations about contraception

A small number of participants indicated that they had not sought any consultation prior to the decision to use family planning (Table 13). The conversations varied between men and women. Women indicated that they had not consulted anyone due to concern with their spouse/partner's disapproval of family planning.

All of the men who indicated they had not consulted anyone were currently using condoms and felt that since it was a commonly available and a male-controlled FP approach they did not need to consult with anyone prior to use.

Table 13: Whom did current users consult about contraception and contraceptive choices?

<table>
<thead>
<tr>
<th>Kilifi</th>
<th>Mtwapa</th>
<th>Iyabe</th>
<th>Nyamagundo</th>
<th>Male (N=35)</th>
<th>Female (N=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ganze (N=20)</td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
</tr>
<tr>
<td>Spouse</td>
<td>10(50)</td>
<td>13(76)</td>
<td>12(71)</td>
<td>11(65)</td>
<td>21(60)</td>
</tr>
<tr>
<td>Health Provider</td>
<td>11(55)</td>
<td>4(23)</td>
<td>5(29)</td>
<td>6(35)</td>
<td>17(49)</td>
</tr>
<tr>
<td>Peer</td>
<td>7(35)</td>
<td>5(29)</td>
<td>7(41)</td>
<td>4(23)</td>
<td>8(23)</td>
</tr>
<tr>
<td>Family</td>
<td>3(15)</td>
<td>-</td>
<td>2(12)</td>
<td>-</td>
<td>1(3)</td>
</tr>
<tr>
<td>Nobody</td>
<td>2(10)</td>
<td>1(6)</td>
<td>4(23)</td>
<td>-</td>
<td>3(9)</td>
</tr>
</tbody>
</table>

4.2 Spousal consultation and what they discussed

Across the board, spousal consultation was cited by the most participants as a necessary step prior to any FP decision, emphasized even in general consultations with peers.

“... when she came to me I advised her to go and consult her husband first; explain to him giving birth yearly is not good....talk about how you can space by using family planning, and when he accepts come I will take you [to the health facility]. She went, consulted with her husband, he agreed. So she came and told me she had talked with her husband and he had agreed. I came with her up to here [health facility] introduced her to the doctor, they advised her from the beginning up to the end until she chose what to use.” (Female, 23y, injectable user, IDI)

Participants cited a number of reasons for engaging with their spouse, including mutual respect, joint responsibility for current and future children, and fear about potential health issues with time. As one participant indicated:

“My husband is everything in my life so there is no way I would plan with someone else or alone because if I get any problems I will tell him.” (Female, 28y, IUCD user, IDI)
Additionally, participants also indicated that consulting others, aside from their spouse, would not be culturally appropriate.

“I may advise my friend to use the injection and then they go and tell their husbands that I suggested that they use it, and then he will be upset that they are seeking advice outside their marriage.” (Female, 31y, injectable user, IDI)

Several women who echoed these statements indicated that family planning was a private affair: “It’s a secret between you and your husband...and the service provider.”

Participants indicated discussing a range of topics with their spouses, including:

- **General discussion to initiate FP use:** “It wasn’t a one day thing... because my partner wasn’t seeing the importance of family planning... at first my partner couldn’t listen. So after some time she finally understood.” (Male, 32y, partner of injectable user, IDI)

- **Reasons for family planning:** “You can see that these children have people to take care of them. But now if you get like say ten children, and your wages are about a hundred shillings [less than US$1], you see that is punishing a child. So on my part, we sat down and discussed about it, we decided to plan our family in a manner that we could be able to. Because children, children, it is not good for them to suffer.” (Male, 35y, partner of implant user, IDI)

- **Information about FP methods:** “You know women in their meeting they always talk a lot. We also talk as men. Therefore she might have learnt that from other women. So when we sat down and started talking about family planning issues, she also told me that at times she sits with her fellow women, and there are also those who use these methods of family planning. And that we let our children have enough space or gap between them.” (Male, 34y, partner of injectable user, IDI)

- **Potential side effects from FP methods & method choices:** “At times these issues of family planning, pills, injections have side effects. Therefore, at first we had lots of questions like if you start using them, will this method bring you side effects? But we didn’t take our arguments far, we decided either way that we had to do it.” (Male, 34y, partner of injectable user, IDI)

  “Even him [my husband]... about the coil... I don’t know where they were taught, because he told me even if you go there do not choose the coil. It is better those others; he told me the operation can bring you high blood pressure... that is how I chose the injection.” (Female, 28y, injectable user, IDI)

### 4.3 Consultations with health service providers

A fifth of participants across all sites indicated that they had consulted with a health care provider prior to starting a FP method. Participants cited a number of reasons for consulting a health worker, including information about FP methods and side effects, as well as assessment of eligibility for certain methods.

Twice as many men as women indicated that they had consulted with a doctor. Although participants were not asked directly, a few male participants indicated that it was not socially acceptable to discuss
family planning with peers. This may help explain the larger number of men who indicated they consulted a doctor.

About two-fifths of participants from Kilifi (15 of 37) indicated they had consulted a health worker. A few participants in Ganze mentioned previous FP initiatives sponsored by local leaders and health centers:

“Those teaching are put there... they [community members] are taught in the chief’s barazas [weekly public meetings]... they teach about family planning; plan, space your children, take care of this one then after some time you can give birth again... it is not that when you go for family planning you will stop giving birth completely. We were educated... you will go home and think over it. There are those [methods] for three years, we were taught that and that is how I decided to come and start resting [birth spacing].” (Male, 28y, partner of IUCD user, IDI)

Another participant in Ganze cited information provided by health workers as an impetus for deciding to begin family planning. This additional outreach, which was not reported to this extent at other sites, could explain why more participants in Kilifi reported consulting health care providers prior to FP uptake.

4.4 Consultation with peers
A fifth of all men and almost half of all women indicated that they had consulted with peer prior to making an FP decision. Participants cited a number of reasons for reaching out to peers, most notably to get recommendations and feedback on specific FP methods.

Participant consultations with peers covered a range of different topics, including:

- **Recommendations for beginning FP:** “They were just telling me, and they laughed at me because I gave birth closely, they told why don’t you go for family planning. That is when I told them I have never used any family planning and how do I go, so they told me there are many methods, they told me of the injection... They told me the injection lasts three months and then you go for another. I saw I could manage that one. It will be easy and I will not forget [laughs] so I went.” (Female, 28y, IUCD user, IDI)

- **General discussion about methods:** “There [is] my friend that I went to school with and she had used FP so after using she stopped, and she has never given birth to date. Her last born is sixteen so when she talked to me I decided to try, I asked her which method she was using and she told me the injection and told me if you rhyme with the injection it is the best method.” (Female, 30y, pill user, IDI)

- **Discussion about side effects:** “...we were told that the pill is so bad it has batteries the size of a wrist watch battery inside, so I thought that was not a good method because it can go and heap in my stomach. So I told my friend we go for the injection and she told me that for the injection you cannot forget, unlike the pill you can forget and get a child that is disabled. They also told me of a woman in our village who used the pills and they went and formed a wound in the stomach.” (Female, 30y, pill user, IDI)
• **Discussion about risk of pregnancy and diseases from unprotected sex:** “I am aware there are diseases, and I went to my friend because he is older and he is married and he told me because I am not married it’s not wise for me to go around having sex recklessly and that I should go get examined and that is what I did. So when I came back and told him I was ok, he said because I am not married, I should use condoms as I am still a child.” (Male, 22y, condom user, IDI)

4.5 Consultations with a family member

At least 13 participants, mostly women, indicated that they had consulted someone in their family prior to deciding to use an FP method. A majority of the women indicated that they had spoken to a female family member in an effort to get feedback on the decision to initiate an FP method as well as recommendations on the best FP method, while three had been approached by a female family member following observation that they had either given birth out of wedlock or were having closely spaced births. As one participant, whose husband is a migrant worker, explained:

“The reason I chose my mum is because we stay together and she is my closest friend; even though we talk with my husband on [the] phone, my mum was the one available at the moment and she also advised me that it is a good idea because the husband may come anytime and want sex yet I don’t know my condition. So that is why I took family planning. We did not talk of any other thing. That is what I saw was important... She was the one that came first with the idea of taking family planning procedures and I agreed to it because I was afraid of getting pregnant again soon because of the challenge I had during birth.” (Female, 32y, implant user, IDI)

One male participant indicated he had consulted with a family member—a cousin of the same age—about the need for family planning.
STUDY LIMITATIONS

This formative assessment had several limitations from which context the findings should be taken.

The study was limited to public health facilities offering contraceptive services including FP counseling and a wide range of the method mix. While we did not include other services, such as the private and faith-based organizations offering similar services, expansion of the study target population outside of the health service and at least into a 5-kilometer radius aimed to reduce the bias associated with a given health service delivery point. Indeed, in Kilifi, a private facility offering subsidized family and reproductive health services was a stone’s throw away from the selected public health facility.

The study did not include service providers, though some of the study highlights suggest a possible provider influence in the uptake of services, including perceptions about a provider’s skill to administer methods such as the implant and IUCD. Also, women in the more rural areas of Kilifi and Kisii South appeared to have limited knowledge of contraception, some even of the very method they were using. An assessment focused on providers may unpack their experiences with trying to offer certain methods, the promotional mechanisms they have instituted to engender receptivity to methods that are otherwise unpopular, and the specific technical assistance they may need in overcoming certain challenges. Challenges with counseling individuals and couples of the appropriate method remains of particular importance.

While our study targeted adults 18–35 years of age, interviews with young adults 18–22 suggested limited articulation of contraceptive methods. Their seeming preference for condom use, though laudable for its dual protective advantage, should be understood from this context, to assess for any possible missed opportunities toward addressing unmet need for contraception.
DISCUSSION

Our study findings suggest that the concept of contraception was well understood and gaining acceptance among study participants. Contraception, or “having children by plan,” included 1) starting a family when one is ready to have children (i.e., in marriage), 2) spacing children to enhance the health of both mother and child, and 3) determining and limiting the number of children to a number one could provide for. Family planning was perceived as the gateway to achieving life goals, particularly with the rising cost of living. However, it was apparent from interviews with never users and discontinued users that this appreciation did not necessarily translate into contraceptive uptake and/or continuation, underlying factors of which this study sought to understand.

While there seemed growing acceptance of contraception, with the majority of our female study participants (even non-users) indicating the desire to manage their family sizes, a lot of individuals and couples remained encumbered by fears of potential side effects. Physiological side effects such as weight gain, dizziness, headaches, high blood pressure, and even mild menstrual changes were considered bothersome. The data suggests that these side effects were seen more as reasons for choosing specific contraceptive methods and for switching from one method to another. The more worrisome factor was the potential for physiological effects to disrupt normal functioning, including infertility particularly following prolonged use of certain contraceptives, male impotence, birth defects, and cancerous growths, among others. These were perceived as having severe social consequences including interfering with performance of household chores, farming duties, and conjugal and reproductive roles. Thus, while individuals were concerned about the physiological manifestations of side effects, it is the social consequences of these contraceptive-related fears and misconceptions that may inhibit contraceptive uptake and continuation, particularly in view of the fear not only of infertility but also of social stigma toward childless marriages or birth limiting.

Specifically, except for condoms that were deemed near-natural, all other contraceptives reportedly potentially caused wounds in the womb, compromising fertility and birth outcomes and leading to failure to conceive and birth defects. Pills and injectable contraceptives were most often associated with infertility, cancerous lower abdominal growths, and increased chances of birth defects and/or contraceptive failure, especially should one fail to adhere to the pill regimen or receive an expired injectable. Implants and IUDs reportedly could shift and get lost in the body via the blood stream or into the womb, with serious implications for birth outcomes and strain on family finances should surgery be needed to remove the dislodged method. Though perceived to be non-hormonal, hence potentially safe, the IUCD remained unpopular for reportedly increasing the risk of ovarian problems due to trapped sperms and the embarrassing method of administration.

Despite these perceived challenges, some individuals and couples were able to take up and maintain contraceptive use. It is important to note, however, that similar to never and discontinued users, current users equally harbored contraceptive fears and suggested that all methods were potentially harmful. Notably, partners appeared attracted to methods with minimal side effects as well as those not disruptive to normal functioning. Our study highlighted that factors facilitating the uptake of family planning exist at every level of the socio-ecological model—environmental, community, interpersonal, and individual. A key difference appeared to lie in the balance of pros and cons of using (and perceived magnitude of side effects) versus not using (and perceived consequences of unintended pregnancies). As alluded to above, interviews with current users suggested that the latter—i.e., the perceived cons of not using contraceptives—weighed more heavily. In particular, the main environmental push for determined contraceptive adopters to overcome challenges came from the rising cost of living and
economic implications of a family size that surpassed family income capabilities. Thus, choice of the specific contraceptive method appeared to be influenced by fertility desires at different stages of life (whether the goal was child spacing or birth limiting), and desires for gender balance. At the community level, while successful users considered social information in their initial method uptake, their subsequent uptake of the method or method switch were informed by both their personal observations and search for solutions to an identified potential hindrance. Importantly, contraceptive users appeared to have a sustained relationship with health care providers. Conclusive decisions for method choices among successful adopters were reportedly arrived at following appropriate contraceptive counseling and review of available methods with qualified providers, plus follow-up consultations about any method side effects. A notable individual and/or interpersonal feature among current users of contraception was the indication of partner dialogue in contraceptive decision making, both for taking up contraception and for method choice. While the negotiation process did not necessarily run smoothly, spousal consultation was cited by most participants as a necessary step prior to any FP decision; for mutual respect for their relationship, joint responsibility as current or future parents, and for assurance of spousal support in view of fears about potential undesirable consequences of FP use.

Nevertheless, contraceptive adopters still had to grapple with other challenges, particularly social stigma against birth limiting for married couples and pre-marital sex and contraceptive use among unmarried young adults. Some coping mechanisms, while resulting in contraceptive uptake, may eventually perpetuate negative experiences with certain contraceptives and further the spread of misconceptions and misinformation along informal social networks. For instance, to avoid the stigma of being seen in FP service areas, school girls shared contraceptive pills, a practice with implications for adherence to the regimen, and in turn, method effectiveness. Some married users insisted on discreet methods such as the injectable or IUCD without consideration of their medical eligibility for these methods, to the extent of declining any medical advice for the appropriate method. Similarly, while successful users indicated their main coping mechanism was to switch methods if certain side effects became severe, perceptions of severity remained relative to the extent some may decline medical recommendation for method switch, with implications for social misconception of contraceptive effects. For these users, particularly those on discreet use of contraception, the suggestion among current users that method choice should be made from an informed point of view, i.e. following consultations with qualified providers, may not necessarily hold.

CONCLUSIONS AND RECOMMENDATIONS

The premise of our study was that while fears and misconceptions inhibited the uptake and continuation of contraception, women and men in these same communities were successfully using family planning methods – indicating a potential to identify and replicate these positive behavior patterns in efforts to improve contraceptive uptake. This formative assessment has attempted to unpack key factors contributing to modern contraceptive fears, misconceptions, and misinformation, and key characteristics of successful users. Results from this research can be used to create guidelines and recommendations for developing evidence-based social and behavior change communication interventions to promote modern methods available in Kenya. Notably, individuals and couples indicate growing receptivity to the concept of contraception, both for child spacing and limiting births. An approach going beyond the generic provision of correct information remains of particular importance. Targeted communication should be designed to address questions regarding 1) the wider social and environmental issues surrounding women, such as the distribution of power and authority; 2) gender-specific norms outside of and within relationships, and 3) misconceptions and concerns associated with
specific contraceptive methods. While we have summarized these at the various levels of the socio-ecological model, our discussion of opportunities for SBCC (illustrated in Figure 5) below cut across these categories, including information, motivation, ability to act, and perceived social norms.

Figure 5: Opportunities for Social and Behavior Change Communication

<table>
<thead>
<tr>
<th>Information</th>
<th>Motivation</th>
<th>Ability to Act</th>
<th>Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>address specific fears &amp; misconceptions</td>
<td>communicate broad benefits of family planning</td>
<td>engage men in FP uptake and advocacy</td>
<td>community level efforts to dispel communication taboos</td>
</tr>
<tr>
<td>promote sustainable relationship with health providers</td>
<td></td>
<td></td>
<td>promote changing norms</td>
</tr>
</tbody>
</table>

**Information**
This study highlighted lack of accurate information sources as a key driver of fears and misconceptions. Communication aimed not only at providing accurate information but also designed to address misconceptions, fears, and side effects, is an important step toward dispelling these barriers.

Along with tailored communication, promoting sustainable relationships with the health care community could establish mutual trust between individuals and the health service. Mechanisms that foster client-provider communication enhance continued FP use; a client that is comfortable asking questions about fears and method misconception as well as reporting side effects may be more likely to discuss options for contraceptive switching if needed, rather than opting for discontinuation.

**Motivation**
The intrinsic motivation to deter unplanned pregnancies among successful contraceptive users is what distinguished them from non-users. Motivation was discussed in varied forms including the economic challenges of raising additional children or children born close together, and the desire to fulfill life goals that would be inhibited by unintended pregnancy. A communication campaign that addresses the variety of reasons that drive individuals to use family planning and avoid unintended pregnancy enhances the opportunity to motivate nonusers by targeting benefits that they may not have previously considered.

**Ability to act**
Male partners, by virtue of their decision-making power and control of financial resources, play a crucial role in the uptake and successful continuation of family planning methods. In both phases of this study women attributed low or late contraceptive uptake to their partners’ reluctance, with some compelled to use covert methods. Significantly, the majority of current users attributed their successful continuation of FP use to partner communication. This underscores the critical need to program male involvement both in uptake and in advocacy, especially to foster communication with partners and providers about side effects and more appropriate contraceptive switching when needed.
Perceived norms
While successful users mostly reported talking to health providers about modern contraception and method choice decisions, the majority of participants overall indicated their family planning “knowledge” came from what they have heard among their peers. The perception that family planning was a “private” matter points to a need to promote community acceptance of modern contraception. Traditional norms favoring large families still pose a barrier to the adoption of family planning methods. However, this study highlights that these norms may be changing, namely due to the economic environment, offering an opportunity to dissolve the fear of community or social stigma that some may associate with using contraception.

CONCLUSIONS AND POTENTIAL APPLICATION OF FINDINGS
This qualitative research study has attempted to unpack key factors contributing to fears, misconceptions, and misinformation related to modern contraception and side effects, and the potential for addressing these barriers through SBCC. Results from this research can be used to create guidelines and recommendations for developing evidence-based SBCC interventions to promote modern methods available in Kenya. Notably, individuals and couples indicate growing receptivity to the concept of contraception, both for spacing and limiting births. An approach going beyond the generic provision of correct information remains of particular importance. Targeted communication should be designed to address questions regarding:

1) The common interaction between misconceptions or misinformation, side effects, and the lack of accurate information, often results in a disproportionate fear of modern contraceptive methods. Importantly, consideration of decision-making process to understand how contraception fits in the lifestyles and fertility intentions of individuals and couples may enhance tailored FP counseling and improve uptake and continuation. In parallel, it is critical to focus on the more practical outcomes and draw attention to previously less recognized benefits such as — a “manageable” family size — as cited in our study, as increasingly important in view of the rising cost of living and limited land resource. In February 2012, the Kenya National Council for Population and Development (NCPD) launched a campaign drive with this message, shifting the focus from national development benefits to household-level benefits. Monitoring the process and effectiveness of such targeted communication is critical to decisions around the development and implementation of similar family focused approaches to engendering contraceptive uptake.

2) The wider social and environmental issues surrounding women, such as the distribution of power and authority, which are in turn shaped by gender specific norms outside of and within relationships. It remains critical to look for innovative ways to address communication barriers surrounding contraception. This is especially needed because decisions around contraceptive uptake are not just about family size, but may also have financial implications including service fees for certain methods — factors traditionally in men’s control. Strategies to increase the involvement of men in reproductive health, particularly in family planning dialogue, serve to create an enabling environment that may be the step towards not only empowering women to negotiate for contraceptive use, but also reducing social communication barriers surrounding FP. Kenya’s National Reproductive Health Strategy 2009-2015 targets male involvement through gender mainstreaming. Multiple approaches have been deployed in this effort, including creation of male friendly family planning clinic environments, and community family planning outreach dialogue sessions facilitated by trained community health extension workers. Questions that should be answered to improve programming are the extent to which
men are accessing FP clinics, and the levels of men’s and women’s participation in community dialogues. The reactions of men and women, including motivations and barriers, provide important lessons for what works in which environment, and why – all important for further targeted intervention.
REFERENCES
