RESEARCH BRIEF

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

OPPORTUNITIES FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

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KEY TERMS
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 birth control methods.

ACRONYMS
C-Change Communication for Change
DRH Division of Reproductive Health
FGD Focus group discussion
FP Family planning
IDI In-depth interview
IUCD Intrauterine contraceptive device
SBCC Social and behavior change communication
BACKGROUND AND RATIONALE

Increasing the uptake of modern contraception is critical to enabling women and their partners to meet their fertility goals and to reduce unmet need for family planning. Fears, misconceptions or misinformation, and side effects (actual or perceived) of methods 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%, which reflects a sizable proportion of the population that is not meeting its fertility goals. The main modern contraceptive methods used in Kenya include injectables (21.6%), pills (7.2%), sterilization (4.8%), implants (1.9%), condoms (1.8%), and intrauterine contraceptive devices (IUCDs) (1.6%).

While modern contraceptive use among currently married women has increased from about 27% in 1993 to 39% in 2009, there is also an increasing trend in reporting “fear of side effects” and “health concerns” as important reasons for nonuse; a two-fold increase from 15.6% in 1993 to 30.7% in 2009.

Understanding barriers to fertility regulation is important for providing programming guidance in relation to the provision of family planning services. Although previous research has identified negative perceptions of contraception as reasons for nonuse, this research sought to build on the evidence base and use qualitative research to further explore these complex issues.

Between May 2011 and July 2012, the Communication for Change (C-Change) Project collaborated with the Division of Reproductive Health/Ministry of Public Health Services and Sanitation in Kenya in a formative 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.

OBJECTIVES

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 under the first objective were: 1) What are people’s method-specific fears and 2) What are the key drivers of these fears? Under the second objective the questions 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. Both phases were conducted with men and women ages 18–35 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 modern contraceptive prevalence is roughly 32%.²

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 nonusers of modern contraception. For objective 2 (Phase II) only IDIs were used. Researchers were interested in the personal experiences of current users of commonly available modern contraceptive methods (including pills, injectables, IUCDs, implants, and condoms, and

where applicable, permanent methods such as tubal ligation and vasectomy).

Participants were recruited from within the catchment area of a public health facility that provided 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.

**KEY FINDINGS**

**Overview**

The majority of participants were peasant farmers or housewives; some were teachers and owners of small business enterprises. The data suggested that people across the sites understood contraception 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 number one could provide for.

In both study phases, women and men listed a range of contraceptive methods they generally knew of (or had heard of, if not already seen or used). The most commonly known method was pills, followed by injectables, and 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 they had tried before or were currently using.

The terms contraception, family planning (FP), and contraceptives are used interchangeably to denote modern means of pregnancy prevention, child spacing, or birth limiting.

**Objective 1**

Researchers conducted 44 IDIs and 33 FGDs. The median age and years of education among IDI participants across the sites was 28 and eight, respectively, and was similar for FGD participants.

**Fears and misconceptions related to modern contraceptives**

Women and men across study sites discussed a wide range of fears centered on the following themes: 1) 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.³

Pills and injectable contraceptives were most often implicated in participants’ reported fears. The pill and injection were associated with infertility, cancerous growths, especially following prolonged use. The two methods were also associated with an increased chance of birth defects, especially when one failed to adhere to the pill regimen, or received an expired injectable.

Contraceptive failure was cited in relation to injectables, which participants indicated could diminish in effectiveness over time or could be non-effective for some individuals. Women cited cases of expired injectables leading to unintended pregnancies. Shifting or expulsion of IUCDs or implants was cited by a number of participants. Individuals perceived that implants could get lost in the body via the blood stream. Similarly, the IUCD reportedly could shift during sexual intercourse; with serious implications for birth outcomes. Shifting of contraceptive method 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, 25 y, user, IDI

³ Reported fears were not necessarily informed by actual personal experiences.
“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, 24 y, user, FGD

**What are participants’ reported side effects of contraceptives?**

The data highlighted several physiological side 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 IUCD, 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 she 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 when she does some small chore she starts feeling bad.”

—Male, 29 y, user, FGD

**Whom do individuals or partners consult about health concerns and contraceptive side effects?**

Well over half of those interviewed reported that peers (friends, neighbors, and relatives) and community health workers were their main sources of contraceptive information. The data also suggest a communication taboo where participants indicated that family planning was a private affair discussed only with close contacts.

“What I know… the women in the village here when they are using a FP 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, 33 y, user, IDI

As indicated in the illustration above, women in Kisii South particularly feared witchcraft. They reported that knowledge of their contraception use could make them a target of witchcraft, exposing their existing children to death and rendering them childless. In Kilifi, women feared social scorn for using contraception; a marriage is traditionally supposed to result in children, the more the better. Often, based on initial consultations with peers and others, a decided prospective user visited the health service with an idea of her preferred method and requested “fast service” lest other people learn why she made the visit. Although interviews with participants in Kilifi suggested the full method mix was often presented, service providers indicated that the desire for “fast service” left little room to sensitize clients on all methods, 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, 34 y, user, FGD

**What are the perceived outcomes of fears, misconceptions, and side effects?**

Fears and misconceptions appeared linked to two undesirable outcomes (figure 1). One is related to the inability to fulfill the reproductive role in the family, which is problematic given the high value that is placed on fertility. The other is connected to the rising

<table>
<thead>
<tr>
<th>FIGURE 1: PERCEIVED OUTCOMES OF FEARS, MISCONCEPTIONS, AND SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FEARS AND MISCONCEPTIONS</strong></td>
</tr>
<tr>
<td>inability to fulfill reproductive role in family</td>
</tr>
<tr>
<td>financial &amp; emotional burden on relationship</td>
</tr>
<tr>
<td>inability to work or fulfill household duties</td>
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<tr>
<td>decreased sexual activity</td>
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<td>economic and emotional strain, abandonment by sexual partner, &amp; community stigma</td>
</tr>
<tr>
<td>changes in normal functioning, disruptions in sexual relationships</td>
</tr>
<tr>
<td><strong>SIDE EFFECTS</strong></td>
</tr>
</tbody>
</table>
cost of living. These intertwined with severe social consequences, including economic and emotional strain in a relationship, fear of abandonment, and general community stigma.

For instance, both men and women indicated the fear of contraceptive failure, suggesting it may result in additional children and lead to the severe consequence of economic strain on the family. Additionally, many women not using contraception suggested that while spousal objection to contraceptive use was a key barrier, their overriding related concern was spousal abandonment should complications later develop. A serious complication such as cancer or a birth defect could not only make it difficult for a woman to fulfill her reproductive role in a marriage, but also have financial implications in terms of medical costs. In effect, women who cannot overcome fear of spousal abandonment or neglect in case of method complications may likely opt not to use contraception until their spouse agrees to it. On the other hand, those who could overcome this fear likely opted for covert use of contraception and may take up a method that is not medically suited to them just because it offered the immediate benefit of discreet use.

Social stigma was cited as a severe consequence of infertility as was the inability to bear children following prolonged contraceptive use. Notably, inability to bear children not only was a concern for women but also for men as some participants indicated that male impotence could result from the use of female contraception. Women’s and men’s discussions about physiological side effects, such as high blood pressure and dizziness, centered on the potential loss of productivity. Men and women indicated that as a result of these side effects, individuals would be unable to continue working or fulfill normal obligations within the household. Participants also discussed changes in libido as a result of these side effects, which would also inhibit sexual activity, causing disruptions in sexual relationships.

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 as illustrated in figure 2 below, were major detractions to the initial uptake of family planning, and potentially to the discontinuation of family planning use altogether (if the option to switch methods was not available).

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 barriers to contraceptive uptake. Instead they were seen as reasons for choosing a specific contraceptive method or for switching from one method to another.

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 be disastrous, including fear not only of infertility but also of community stigma.

**Objective 2**

The premise for objective 2 was that while fears and misconceptions inhibited the uptake and continuation of contraception, women and men in these same communities are successful users of family planning methods. The second phase of this study thus sought to identify the factors that facilitate successful uptake and use of contraceptives.

Seventy IDIs were conducted with adult male (35) and female (35) participants currently using modern contraceptives, including injectables (20), male condoms (17), hormonal contraceptive pills (13), implants (10), IUCDs (6), and female sterilization (4). Researchers conducted an analytical review of these
At the broader environmental level (figure 4), 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.

“...we sat and discussed the other day, and I told him that we are even lacking food for the children we have now. It is good we go to the seminar and get in depth information. ... so that we can … we can be able to have a good life.”

—Female, IUCD user, IDI

As illustrated in the quote above, the intrinsic motivation to avoid unintended pregnancy among married or single participants was to have a good life. This was variously described as the ability to provide and care (food, education, and clothing) for their current family; comfortably meet financial obligations; promote better mother and child health through birth spacing; among others. Participants in casual partnerships wanted to avert pregnancy in order to protect their future, including completing school and increasing the chances of getting married to the person of their choice.

At the community level, while current users indicated having multiple sources of family planning information, they particularly 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 not only to consult about fears and specific misconceptions, but also to explore options for switching methods if they experienced side effects, as the quote below illustrates:

“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 cannot stay in my stomach.”

—Female, 30 y, pill user, IDI

Interviews using the C-Change socio-ecological model (figure 3) to understand differences between successful and unsuccessful contraceptive users.

What are the notable characteristics of successful contraceptive users?
The findings suggest that factors facilitating the uptake of family planning exist at every level of the socio-ecological model – environmental, community, interpersonal, and individual.

While the findings below are summarized by the various levels of the socio-ecological model, the discussion of opportunities for SBCC cut 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 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 non-users 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

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**IMPLICATIONS FOR SBCC**

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A notable individual and/or interpersonal feature among current users of contraception was the indication of partner dialogue and/or involvement throughout the family planning process. A female or male partner initiating a family planning 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 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.

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**FIGURE 5: INDIVIDUAL AND INTERPERSONAL FACTORS**

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**FIGURE 6: OPPORTUNITIES FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION**

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**INFORMATION**
- address specific fears & misconceptions
- promote sustainable relationship with health providers

**MOTIVATION**
- communicate broad benefits of family planning

**ABILITY TO ACT**
- engage men in FP uptake and advocacy

**NORMS**
- facilitate community level efforts to dispel communication taboos
- promote changing norms
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, 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 to lessons for what works in which
environment, and why — all important for further
targeted intervention.

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5 Enhanced Mass Media Campaign and Public Education
For Family Planning
http://ncpd-ke.org/page/enhanced-mass-media-campaign-and-
public-education-for-family-planning-underway
