FAMILY PLANNING
IN KENYA AND THE PROBLEM
OF DROP OUTS

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ABSTRACT

For this study, 160 women were selected at random from among those who had dropped out of the family planning programme in Kisii District and were interviewed using a questionnaire. The study was aimed at finding out why some women discontinue family planning practises very soon after adapting them. It was found that, among several factors which influence the family planning drop out rate, the most important are social and cultural influences, the clients' failure to follow instructions and medical problems.

INTRODUCTION

The desirability of family planning programmes is currently being debated in many African countries. In those countries where programmes have actually been established, a major concern has been to secure the approval and acceptance of contraceptives by a large part of the population. Studies of family planning knowledge, attitudes and practises (known as K.A.P. studies) have shown consistently that most of the public approves of family planning in the abstract. However, clinical records show that very few of those who approve of family planning actually adapt contraceptives.

When a programme is first initiated, the small number of early adapters are usually highly motivated and are likely to continue using contraceptives for at least twelve months. Those subsequently recruited into the programme are likely to drop out almost as soon as they are enrolled. Family planning workers are busy promoting family planning among new recruits and administrators are busy coping with organisational problems, so that there is rarely any effort to follow up on those who have dropped out of the programme. Reports mention first visitors and revisitors (potential acceptors and those who have already accepted) without mentioning previous acceptors who have dropped out. However, it is important to bring these drop outs back into the programme or at least to discover and correct the factors which led them to drop out, because these dissatisfied former clients could be quite harmful to the future success of the programme.

Kenya has an active Family Planning Association and a well developed government programme, with about 50,000 women visiting family planning clinics each year.[1] Of these in 1973, 47,342 were said to have accepted some method of contraception, while the remainder were infertile or did not accept a method for other reasons. Although these figures are high and speak well for the efforts of Kenya's family planning workers, it is also estimated that as many

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1. The actual figure for first visitors in 1973 was 50,054 and for revisitors 211,301. See 5. A first visitor is defined as a client who visits a reporting clinic for the first time. A revisitor is a client who attends the same clinic in which she is registered as a first visitor for the second or subsequent times. An acceptor is a client who visits a family planning clinic and accepts the use of a contraceptive method. A drop out is a person who stops using a contraceptive method without explaining or changing to another method.

women drop out of the programme in any given month as are newly recruited.[2]

If this is so, the drop out level is a major weakness in the national family planning programme and the underlying causes should be ascertained and corrected. This paper is the result of research on family planning drop outs conducted in one district in Kenya, and it is hoped that such research will contribute to a solution of the drop out problem.

METHODOLOGY

Between March and June, 1973, 110 women from Kisii District who had dropped out of family planning programmes were each interviewed once using a questionnaire consisting of 124 items. Questions covered the family planning knowledge, attitudes and practises of these former clients and then the possible factors which led them to drop out. Other than medical reactions and side effects from particular contraceptives, respondents were asked about their reception at family planning clinics, the explanations they had received, the distance from their homes to the nearest clinic and the availability of transportation to and from the clinics. It was hypothesised that these factors might have led these women to drop out of the family planning programme. To some extent, these questions were also designed to evaluate the performance of family planning field workers and clinical staff from the client's point of view, but this evaluation is not reported here.

Sampling and Sample Size

From the records of the six clinics in Kisii District which offer family planning services, it was learned that over 3,000 women had registered and 610 of these had subsequently dropped out. Women were considered to have dropped out if they had not reported to the clinic for six months or longer past the time when they were expected to report, or for I.U.D. users, if they had not reported to the clinic for one year from the date of insertion.

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2. In a study which followed 1,465 women using contraceptives, it was found that 39 per cent of those using methods other than the I.U.D. never returned after the initial visit to the family planning clinic. Only 18 per cent of the original acceptors returned for the fourth visit, which is within one year of original acceptance for methods other than the I.U.D. By the ninth visit, two years after initial acceptance, only 2 per cent of the original acceptors were still returning. See 4, pp. 9-29, especially Table 2, p. 18.

A multistage sample was drawn up in which the population of 610 women was divided according to which of the six clinics they had attended and further according to the year in which they dropped out. From this a sample of 160 cases was selected which represented 26.2 per cent of the population. For example, the sample from Kisii District Hospital, with the majority of clients in the District, was drawn up as follows:

Table 1.

Name of Clinic: Kisii District Hospital	Year Dropped	Number of Drop-Outs	Sample Size
	1968	14	3
	1969	45	10
	1970	197	44
	1971	161	36
	1972	0	0
Totals		417	93

Card numbers were listed on separate slips of papers, folded and the required number drawn. Then each number drawn was written at the top of a questionnaire and the name, address and location of the client added as obtained from the clinic records.

From this sample of 160 women, 110 were actually interviewed, nearly 69 per cent. Of the 50 who could not be reached, 19 had moved permanently to other parts of the country, 5 refused to be interviewed, 4 could not be found at home in spite of repeated visits, and 22 were untraceable, apparently having given false names and addresses to the clinic staff.

Interviewing Problems

In conducting surveys in Africa, it is often difficult to locate respondents. For example, in Kisii society the women are not widely known. The clinic cards contained only the names of the women and their husbands, but to locate the women we actually needed to know not only their names and their husbands' names, but also the names of their husbands' fathers, the names of their clans, and the names of the markets nearest to their homes.

It also happens frequently that a respondent is away from home, so that arrangements for a revisit must be made. In this way, one whole day may be spent obtaining only one interview.

CHARACTERISTICS OF THE RESPONDENTS

Of the 110 respondents, at the time of the interview 100 were married, 5 were unmarried, 4 were widowed and 1 was divorced. Two women were in the 15 to 19 year age group, 17 were between 20 and 24 years old, 25 were between 25 and 29 years old, 28 were between 30 and 34, 20 between 35 and 39, and 18 were over 40. Thus 83.7 per cent of the women were in the most fertile age groups and could be said to be most in need of contraceptives.[3]

In terms of education, 28 per cent of the respondents had no formal schooling, 24 per cent had completed between 1 and 4 years of primary school, 41 per cent had completed between 5 and 8 years of primary school, and 7 per cent had 9 years of education or more.

When asked their occupations, 74 per cent of the respondents identified themselves as housewives or self-employed. On the question of religion, 61 per cent said they were Protestants, 26 per cent said they were Roman Catholics, 11 per cent said they had no religion, i.e. they were traditionalists, and 2 per cent said they were Moslems. Nearly all the respondents (107) had children; only 3 had none.

When asked if they had all the children they wanted, 41.8 per cent said yes, 55.5 per cent said no, and 2.7 per cent refused to answer. Those who wanted additional children were asked how many more they wanted, and 48.4 per cent wanted 1 or 2 more children, 40.3 per cent wanted 3 or 4 more children, and 11.2 per cent did not know.

The respondents were also asked which contraceptive method they had been introduced to at the family planning clinics, and 89.1 per cent recalled that they had been given oral pills, 4.6 per cent had been fitted with I.U.D.s, 2.7 per cent had been given condoms, 2.7 per cent had not adopted any method and one woman could not remember. This was verified from clinic records.

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3. While the internationally accepted age for menopause is around 49 years, in Kenya few women continue to have children past the age of 40. Since most African women start having children while they are still young, by the time they are 40 many already have large families. Those who go to clinics to seek contraceptives after this age usually want to stop having children altogether.

These responses were not surprising because, although nearly all forms of contraceptives are available in Kenya, family planning workers in the rural areas generally recommend only three methods: the oral pill, the I.U.D. and the condom. It is not clear whether the limitation of discussion to these three methods represents a valid judgement concerning which types of contraceptives will be acceptable to the rural population or whether it merely represents personal prejudices on the part of the family planning workers.

FACTORS INFLUENCING THE DECISION TO DROP OUT OF THE FAMILY PLANNING PROGRAMME

The women were asked if they returned to the clinics every time they were expected to, and 59.1 per cent said they did not. Another 33.6 per cent said they never returned, and the others gave no answer.

A number of reasons can be hypothesised for a woman to stop participating in a family planning programme. She may want to become pregnant after a period of rest; she may experience community pressure to withdraw from the programme; she may experience side effects from a specific contraceptive and for some reason not change to another method; she may have reached menopause and therefore have no more need for contraceptives; she may find supplies difficult to obtain; or she may not be satisfied with her reception by family planning workers. The respondents in this study cited a variety of reasons for not returning to the family planning clinics. Some of the most often cited reasons were: "I had decided to stop"; "I conceived while on the method", "My husband forced me to stop","I finished the pills and had no time to visit the clinic" and "My child died". Only three respondents said they had become dissatisfied with the clinical services.

For further discussion, the reasons given in this study for discontinuing with family planning can be broken down into medical reasons, including failure to follow instructions, transportation problems and socio-cultural factors. The numbers of respondents citing each of these reasons are given in Table 2 at the end of the paper.

Medical Factors: Methods of Contraception

As mentioned earlier, the oral pill, the I.U.D. and to a lesser extent the condom are the contraceptive methods most often recommended to rural women in Kenya. The decision to continue using a particular method depends on its

good and bad effects as experienced by a woman herself or communicated to her by others. The respondents were asked to name the good and bad effects they had experienced "while using the pill", and 27.3 per cent said the pill was good because it regulates the monthly period, 61.8 per cent said the pill was good because it prevents pregnancy and permits the spacing of children, 20 per cent said there was nothing good about the pill, and 18.1 per cent said they did not know of any good effects of the pill.[4] When asked to list bad effects of the pill, 15.5 per cent of the women mentioned that it is "costly",[5] 11.8 per cent said that it causes backache, bleeding, headache, stomachache, etc., 8.2 per cent said that the pill delays desired pregnancies, 27.2 per cent mentioned that the pill closes the uterus, affects the mammary glands, makes one weak and allows one to become pregnant unexpectedly. The other respondents either did not see anything wrong with the pill or did not know.

The women were further asked if they themselves had actually experienced any of the problems they had mentioned, and slightly more than half (58 respondents) answered in the affirmative. Eight women answered that they become fat and weak, 19 mentioned that they were unable to become pregnant again as soon as they wanted, 18 mentioned being dizzy and hungry most of the time, and 13 complained of backache, stomachache and irregular monthly flow.

The respondents were also asked to list the good and bad effects of the I.U.D. On the positive side, 34 women mentioned that the I.U.D. is less costly, 14 said that it is a more certain way of preventing pregnancy, and 10 said that using the I.U.D. causes less suspicion. The women mentioned bad effects of the I.U.D. which they had experienced themselves along with effects they had heard about from their friends. Twenty-seven women said that the I.U.D. causes irregular bleeding, backache, headache, pus, etc., 18 said that it could disappear into the stomach and possibly necessitate an operation (Although after further probes it turned out that none of these women actually

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4. Multiple responses were allowed so percentages will total more than 100.

5. Because the pill and other contraceptive methods are given free of charge by all government clinics and mobile units, it is difficult to interpret the respondents' use of the word "costly". Perhaps, they meant that the pill is costly in terms of time spent visiting the clinics and remembering when to take it.

knew of anyone who had undergone surgery because the "I.U.D. had gone into their stomach"), 4 mentioned that the examination before insertion is painful, 7 mentioned feeling sick when nearing the time for a period, and 4 said that the I.U.D. could fall out if one is bleeding heavily.

If the respondents did actually experience the negative side effects they mentioned when using the pills or the I.U.D., it is likely that this is what led them to drop out of the family planning programme. It is important that these possible side effects be explained to each client during her first visit, and also that a thorough follow-up be initiated soon after a woman adapts any particular method. Unless this is done, there is not only a danger that these women will drop out of the programme themselves, but also that they will negatively influence many other potential family planning adopters to the great detriment of the programme.

When asked to name the good effects of the condom, 14 women said that there was nothing good about it, 7 mentioned that "the woman is never involved", 9 said that it is less costly, and 6 said that it causes no ailments. The women were asked the effects of using a condom, and 6 mentioned that it is not comfortable for women, 7 said that men were not free to use it, 8 said that it might break and fail to prevent pregnancy, and 6 said that there was nothing bad about it. The large number of women who did not give any opinion about the condom were those who knew very little about it and had no experience with it.

Transportation Problems

It has been hypothesised that transportation problems have led many rural women to drop out of family planning programmes. Such problems would be a lack of reliable transportation to and from the family planning clinics, high transportation costs and bad weather. These factors assume greater importance because it is the policy of family planning workers to give only enough contraceptives at one time to last for three months, with of course the exception of the I.U.D. Furthermore, during planting, weeding and harvesting times most rural women are unwilling to leave their farms to go to a family planning clinic unless it is within a few minutes' walk from their homes.

To test these hypotheses, the respondents were asked how they travelled to the family planning clinics, and 67.3 per cent said that they travelled by bus and 32.7 per cent said that they walked. The time taken to travel to and from a clinic varied from just under one hour to more than three hours. Clearly, unless a woman were very highly motivated or had another errand which took her near the family planning clinic, she might become discouraged by the time required to obtain contraceptives.

Transportation factors are closely related to the ease of obtaining contraceptives. Respondents were asked if they found it difficult to obtain contraceptives, and 54.5 per cent found it easy and 33.6 per cent found it difficult. A further 11.8 per cent did not know. The women mentioned specific problems which were related to the difficulties of travelling to and from the clinics, such as "inability to send someone to collect the contraceptives particularly in times of illness" and "there is no one to leave at home". Only five women thought that "too much time was wasted at the clinic".

In response to these transportation problems, some have recommended that family planning information and contraceptives be distributed outside the clinics closer to the women's homes. This might be especially appropriate in Kenya where some women are willing to adopt a family planning method but are not sufficiently highly motivated to travel long distances every three months.

Socio-Cultural Factors

It seems that the majority of women in rural Kenya will not be willing to use contraceptives for long periods of time if those other people whom they consider important do not support the idea and if it goes against accepted community norms. Continuous reassurance from family planning workers will probably not be effective as a counterbalance to negative community pressure, especially if the family planning workers are outsiders to the local community.

Respondents were asked if their clan or lineage approved of family planning, and 81 per cent of these women, who had at one time adopted family planning, said that their clan or lineage disapproved. A further 15 per cent

said that they did not know, and only one 45-years-old woman said that her clan or lineage approved. Those who had replied that their clan or lineage disapproved were further asked whether this disapproval was moderately strong or very strong, and 54.6 per cent said that it was very strong and 26.4 per cent said that the disapproval was only moderate.

When clan or lineage disapproval was correlated with age, it was found that 70 per cent of the respondents between 20 and 34 years indicated that disapproval was very strong. This seems to indicate that women in the peak child bearing years experience the greatest social pressure to have children, and this must have been certainly an important factor in influencing these women's decision to drop out of the family planning programme.

The women were also asked whether they felt religion was opposed to family planning, and 64.6 per cent answered that they thought it was opposed, 44 per cent feeling that this opposition was very strong. In Kisii District many people profess to belong to an organised religion, but traditionalist beliefs are still widespread. For this reason, it is difficult to assess which set of beliefs the respondents were referring to when they stated that they consider religion opposed to family planning. Although the Christian teaching of "Go ye and multiply" may combine with traditional pressures in favour of fertility, there is no evidence in the history of Kenya's family planning movement of any organised opposition on religious grounds. (see 3.) The point here is not whether or not organised religions in Kenya are in fact opposed to family planning, but rather that the majority of the respondents in this study believed that they are.

CAN FAMILY PLANNING ADOPTERS BE USED TO HELP EXPAND THE PROGRAMME?

It has been suggested that satisfied family planning adopters could be used as agents to persuade others in their communities to join the family planning programme. However, it has also been observed that rural people are reluctant to talk with members of their communities about family planning, particularly if they themselves are using contraceptives. The women in this sample, of course, would not be appropriate agents for enlarging a family planning programme because they were not satisfied adopters, but it was felt that questions in this area might solicit some useful information.

Respondents were asked whether they would recommend family planning to anyone: 71.8 per cent said they would not, only 23.6 per cent said they would and 4.6 per cent were not sure. Of those who would be willing to recommend family planning to others, 20 women said they would because "others should know the value of small families", 4 said they would only be willing to talk to women "because it is easier to talk to women", and 2 mentioned the benefits of spacing children as the main reason they would be willing to talk with other women.

Those who said they would not talk with anyone about family planning gave several reasons for their attitude. Some of the reasons cited most often were: "People might think I want to bewitch their children and in turn might bewitch mine", "Because I do not like family planning", "No one in my area wants family planning", "Family planning is considered secret", "It is not good to do so in our clan", "It is not my business" and "I do not want it to be known that I am practising family planning".

CONCLUSION

In doing a study of this kind, the difficulties of defining terms and measuring the data with some degree of accuracy are enormous. For one thing, it is not a simple matter to define who is a family planning 'acceptor' and who is a 'drop out'. When family planning workers are trying to recruit new clients at group meetings or at maternal and child health centres, they frequently give women samples, especially of condoms. Subsequently these women may be listed as acceptors, even though they never accepted the idea of using contraceptives and probably never gave the condoms to their husbands. (See 1.) Obviously this type of data is very misleading.

Do we call a woman who came to a clinic, was given a contraceptive (other than the I.U.D. or injectable Depo-Provera), took it home, but never returned an acceptor ? Do we call her a drop out? How long must a woman use a contraceptive on a continuous basis before we call her an acceptor? These questions create serious problems when planning a follow up project to bring women back into the family planning programme or at least discover their reasons for dropping out.

And yet according to any definition of terms, the drop out problem in the Kenya family planning programme is very significant, and urgently in need of remedy. In their contacts with clients and potential clients, family planning workers have not always taken into account the general ignorance and profertility values of the community of which the women are a part. For example, in family planning campaigns many hours are spent by field workers explaining the physiology of human reproduction as well as explaining each method. Whether heavy investment in this type of education, particularly among rural illiterate women, is justified remains to be seen. Studies in Latin America have shown that many of the women do not remember much of what they are taught about physiology. (See 2.)

We would recommend that family planning be presented as part of a package including general information and services in the areas of health and nutrition. Furthermore, any family planning programme in Kenya which ignores the role of men is doomed to failure. Women in Africa, in general, do not decide the number of children they want independently, and a woman risks great difficulties if she uses a contraceptive without her husband's knowledge and is later found out. Husbands must be persuaded to participate in family planning decisions, and the attitudes of the whole community must be taken into account for a programme to attract participants and keep them from dropping out.

Table 2. Reasons for Contraceptive Discontinuation.

Rumours	Disappointed Expectations	Medical Reasons	Sociocultural Reasons	Economic Reasons: Transportation	Failure to Follow Instructions	None
Pills would make me sterile (3)	Was not helped to get a girl (2)	General discomfort (2)	Wanted to have necessary children first (14)	No money for transportation (4)	Forgot pills and became pregnant (15)	No reason (7)
Methods would kill me (4)	Was not given method I wanted (6)	Sickness (12)	Husband stopped me (13)		Became pregnant while practising[a] (19)	Don't know (4)
		Switched to withdrawal method (6)	Feared witchcraft (7)			
			Family against contraceptives (3)		Failed to get resupply (13)	
			Divorced, separated or widowed (6)			
Totals 7	8	20	43	4	47	11

The numbers in brackets are the numbers of respondents giving each reason. The total number of reponses is greater than the number of respondents in the sample because some respondents gave more than one reason.

[a]This is a common problem which is normally blamed on the method used. In fact, some women fail to follow instructions and skip a few days during which they are not protected. Sexual intercourse during these days often leads to pregnancy, especially when the contraceptive was forgotten during the most fertile period of the monthly cycle.

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