ARCHES:
Reducing Adolescent and Adult Unintended Pregnancy and Partner Violence in Kenya

Formative Research Report

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LIST OF ACRONYMS

ARCHES  Addressing Reproductive Coercion in HEalth Settings
FGD    Focus Group Discussion
FHOK   Family Health Options of Kenya
FP     Family Planning
IDI    In-depth Interview
IPPF   International Planned Parenthood Federation
LMIC   Low and Middle Income Countries
IPV    Intimate Partner Violence
RC     Reproductive Coercion
SIFPO2 Sustainable Networks
I. INTRODUCTION

A. Project Overview

As a sub-project of a Sustainable Networks (SIFPO2), Family Health Options of Kenya (FHOK), the University of California, San Diego, the International Planned Parenthood Federation (IPPF), and the Population Council are collaborating to increase the uptake of high quality voluntary family planning (FP) in FHOK clinics and to reduce reproductive coercion (RC) and intimate partner violence (IPV) amongst women and girls 15-49 years-old who access family planning services at these clinics in Nairobi, Kenya. This two-year project entails conducting formative research to inform the adaptation of the evidence-based ARCHES (Addressing Reproductive Coercion in HEalth Settings) intervention to the Kenyan family planning context and conducting a clustered evaluation trial to test its effectiveness, feasibility, and acceptability. Specifically, the ARCHES intervention aims to increase contraceptive self-efficacy, decrease incidence of past 3 months RC and IPV, and increase successful (i.e., consistent and without interference) utilization of voluntary family planning methods among female clients of FHOK clinics. If successful, ARCHES provides an opportunity to bring preventive clinical RC and IPV services to scale in Kenya and other Low and Middle Income Country (LMIC) contexts.

B. Purpose of Formative Data Collection

The initial stage of the ARCHES Kenya project is the collection of formative data from family planning clients and providers at FHOK clinics. Formative data provides a foundation for understanding the context to which the intervention will be adapted. More specifically, formative research was conducted to 1) identify the specific forms of RC and other partner-specific barriers to successful contraception among women and girls seeking FP at FHOK clinics; and 2) identify the physical and practice-related clinic structures and personnel capacities in order to guide the tailoring of the messages and structure of the adapted ARCHES model (including adaptation of associated training, monitoring and measurement). Such formative work will maximize the acceptability and relevance of ARCHES Kenya for both FP providers and clients in the Kenyan context.

Formative data collection for this ARCHES adaptation consisted of focus group discussions (FGDs) and in-depth interviews (IDIs) with family planning clients (adult and adolescent) and
IDIs with FHOK clinical providers and managers. Formative research on clients explored the nature and context of RC and IPV among this population, focusing on the specific types and terminology used to describe coercion, violence, and male partner behaviors. This information was also obtained from FHOK FP providers. IDIs with clinic managers and FP providers at four FHOK clinics were also completed to clarify the processes of providing FP services and referrals (including those for IPV services) at FHOK clinics. Additionally, interviews elicited information about ways to feasibly and appropriately adapt the existing ARCHES models’ content, and format, and provider training to fit the needs of clients and providers. This information is essential to ensure successful project implementation in the LMIC and Kenyan contexts.

II. METHODS

Formative data collection took place in four selected FHOK clinics—three in Nairobi County (Eastleigh, Kibera, and Jerusalem) and one in Kiambu County (Thika). The study sample consisted of female FP clients (age 15-49) who sought services at any of the four FHOK clinics involved in the study, and FP clinic managers and providers within the same clinics. Audiotaped IDIs were conducted with female FP clients, FP clinic managers, and FP providers. In addition, audiotaped FGDs were conducted with female FP clients, as depicted in the Table 1.

Table 1: Data Collection Methods and Sample Population

<table>
<thead>
<tr>
<th>Who?</th>
<th>What?</th>
<th>How many?</th>
<th>Which FHOK clinics?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female FP Clients</td>
<td>FGDs</td>
<td>4</td>
<td>Eastleigh (1 FGD, ages 15-24) Jerseyum (1 FGD, ages 25-49) Kibera (1 FGD, ages 15-24) Kibera (1 FGD, ages 25-49)</td>
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<tr>
<td>Female FP Clients</td>
<td>IDIs</td>
<td>11</td>
<td>Kibera (6) Jerusalem (4) Thika (1)</td>
</tr>
<tr>
<td>FP Clinic Managers</td>
<td>IDIs</td>
<td>3</td>
<td>Jerusalem (1) Kibera (1) Thika (1)</td>
</tr>
<tr>
<td>FP Providers</td>
<td>IDIs</td>
<td>8</td>
<td>Eastleigh (2) Jerusalem (2) Kibera (2) Thika (2)</td>
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</table>
III. RESULTS

A. Forms of Reproductive Coercion

RC specifically includes behaviors in one of three categories: pregnancy coercion (i.e., threats of violence or other forms of coercion or pressure for a woman to become pregnant against her will); birth control sabotage (i.e., active interference with a contraceptive method by a male partner – hiding, destroying, or removing it); and limiting contraceptive choice (i.e., coercion or pressure for a woman to not use the contraceptive method of her choice). All three forms of RC were featured in the narratives of FHOK providers and female FP clients during the IDIs and FGDs, and are summarized in the sections that follow.

Pregnancy Coercion

The process of pregnancy coercion, as depicted by client respondents, included threats of violence when women would prevent pregnancy against their partners’ wishes. Some clients also cited that threats of violence or verbal abuse transitioned to actual violence over time. Interestingly, many clients spoke about the struggles of friends or family members rather than their own experiences.

“I have a sister-in-law who has three children – two boys and one girl – so she was satisfied with the number of kids she had, but it’s like, her husband wasn’t. So she was using family planning secretly. Eventually, he suspected she was using injectables and warned her completely against doing that. It became completely unbearable. It then turned to violence in the house.”

-FP Client, Jerusalem FHOK Clinic

“My sister’s case was even worse. Hers even got physical and her clothes were torn simply because the husband wanted a child. Not that she doesn’t have a child, but the husband thinks that she is taking too long to have another child as the one that they have is in Class Two.”

- FP Client, Kibera FHOK Clinic

Another example of pregnancy pressure involved a woman being locked out of the house by her male partner to coerce her to stop using FP.
“[My] friend has had it rough. There are times that...he refuses to open the door for her. He says he will only open it on the condition that she stops using family planning methods. One day, he threw her clothes out.”
-FP Client, Kibera FHOK Clinic

Additionally, clients described situations in which mothers-in-law threatened violence or were verbally and/or physically abusive when they found out women were using a FP method, or stated that they did not want to become pregnant.

“There is a neighbor of mine, the husband did not want her to be injected, it got to a point it caused problems, he told her that he wanted her to give birth and the wife on the other hand does not want to give birth again. It got to [a point where] the mother-in-law could come they quarrel her the whole night and abuse her. It forced that lady to stop using injection.”
-FP Client, Jerusalem FHOK Clinic

“Because she [the client] gave birth to one child, the mother-in-law has always been abusive to her to the extent of telling her that she [the mother-in-law] didn’t allow the client to marry her son to fill the toilets [i.e., to be using the bathroom], but to sire children, as she [the mother-in-law] needs grandchildren, and not her face. There is no peace between her and [her] mother-in-law.”
–FP Client, Kibera FHOK Clinic

Women also discussed pressures to keep getting pregnant and giving birth until they had ‘enough’ children. In the quote below, one woman spoke how her own husband did not understand the concept of birth spacing using contraceptives until after having several children in short succession.

“My husband was against the use of contraception because I had not yet gotten a child and he wanted to have a child and made me stop using it until I had had a child. Then after the first child I went back to using contraception and he stopped me again and after I stopped for the second time, I took time before I got another child because I was from family planning and that was when my husband became worried that the family planning that I was using was the cause of the delay. But after I got the second child, we sat down and talked to him and he agreed that I could now be on contraceptives as he had also seen the way I had closely spaced the children.”
–FP Client, Eastleigh FHOK Clinic
Pervasive in the formative data were instances of FP clients being pressured to get pregnant, with the source of this pressure being not only male partners, but in-laws (mainly parents-in-law and sisters-in-law) as well.

“I have had a series of talks with my mother-in-law and my sisters-in-law. They keep on making calls, inquiring whether I have gotten pregnant. But I am the one who knows the difficulties that I go through, so that is the reason I decided to use family planning despite their being insistent that I have another baby.”

-FP Client, Kibera FHOK Clinic

“I have in-laws. When they come to visit me that is what they talk about [getting pregnant]. They always tell me that they only have one boy in the homestead and that I should give birth so that I can fill the home. By so doing, they are pushing me to get pregnant.”

-FP Client, Eastleigh FHOK Clinic

 “[My husband] tells me that the six girls that my co-wife has, those are hers, and that I should also have more for myself so that I can be at par with my co-wife.”

-FP Client, Kibera FHOK Clinic

In addition to the pressure from partners and in-laws to have more children (especially male children), women also recounted experiences where they were pressured to get pregnant to prove their commitment to their partner or to remain in the ‘will of God’ – the premise of fatalism that outside forces decide an individual’s fate. Women who did not use birth control were in agreement with societal and religious standards(which was perceived as having as many children as possible).

Extended families also relied on their daughter-in-law’s children for their own status and often resorted to coercive means to control women’s fertility. In one poignant case, a respondent discussed being deceitfully given herbal medicines by her mother-in-law to increase her fertility under the guise of a treatment for another ailment she was experiencing. In this circumstance, as well as some others, in-law pregnancy pressure occurred in the absence of direct pressure from a husband or partner.
“She [mother-in-law] came with medicine in a glass, she told me that, ‘I want you to take this medicine, there is your sister in law who was sick, we gave her this medicine and this [amount of the medicine] remained, and I have noticed you always have tonsil problems, and then I felt that we should keep this medication for you.’ I collected that medicine from her, then I told my mum about what had transpired, but finally I came to learn that the herb was meant to make one get pregnant.”

–FP Client, Jerusalem FHOK Clinic

In other scenarios, women described partners who threatened them with eviction, divorce, or marriage to a co-wife if women did not agree to stop using family planning, get pregnant, and give birth to more children. Many clients recounted that often women eventually give into these threats despite concerns around birth spacing or financial hardship.

“Now in that case that lady is so bitter, she is very bitter because the husband wants to marry another wife, and she is already using the injection because she does not want to give birth. Her mother who gave birth to her also told her never to get more than two children because the times are hard. Now this lady is trying to find a way of bringing the husband closer so that they can agree if it is giving birth they can agree because she also does not like the idea of a co-wife.”

–FP Client, Jerusalem FHOK Clinic

“My brother’s wife wanted to use family planning but he forbade her to use any of the methods. She secretly seeks family planning services because if the husband found out, there would be problems. She is afraid that if he found out, he would marry up to three wives.”

–FP Client, Jerusalem FHOK Clinic

“She told me that initially she was using pills, but when her husband realized that she was on family planning pills, he told her to stop, or else, leave the house, as having children was the key factor for them to get married. And the saddest part of it is that they go hungry at times because the husband is not financially stable and they have many children.”

–FP Client, Kibera FHOK Clinic

In some instances, respondents reported that male partners’ both coerced them to stop using FP and claimed that resulting children were not his. This was discussed as connected to the belief that women who use FP do so because they want to have sex with other men. Relatedly, we heard that it is commonly thought that “FP is only for women who are prostitutes.”
“Ok, the husband did not want the wife to do family planning, though she wanted, she did not want to give birth. She was forced, she had to stop the family planning and got pregnant and finally gave birth. After giving birth the man kept insulting her, telling her that, that was not his child and that he knew where she got that pregnancy from.”

–FP Client, Jerusalem FHOK Clinic

**Birth Control Sabotage**

Evidence of birth control sabotage emerged from the IDIs with FP clients and providers in myriad ways. Narratives related to this subject focused on ‘direct’ and ‘indirect’ means of sabotage by male partners. For example, in the excerpts below, FP clients narrate how partners actively/directly interfere with women’s family planning methods by destroying their birth control pills or by forcefully accompanying women back to the FP clinic to ensure interference with or removal of their method.

“I know of one man who put his wife’s pills in hot water to reduce their effectiveness, and she conceived. Later, when she started getting nauseous, her husband told her that she might be pregnant, and disclosed what he did.”

-FP Client, Jerusalem FHOK Clinic

“When I gave birth to my first child, it was via a C-section. So when I told my husband that I needed time before having another child, he would take nothing of that kind, so I was forced to get the family planning method that I was using secretly. But when he realized that I was using family planning, he took me to the health facility where I was getting the family planning methods and warned the doctors never to administer the family planning methods to me. ... I was picked up by my husband and taken to the hospital for the removal of the implant that I had.”

-FP Client, Kibera FHOK Clinic

“My sister-in-law started using pills, but secretly, because she did not want another child. ... So she hid the pills under the mattress. ... When she went to the place she had kept them, she couldn’t find them. Apparently, her husband had already found them and removed those pills there from under the mattress and threw them way. She could not get anything to help her, and that’s how he forced her to get pregnant. Right now, she is suffering.”

-FP Client, Jerusalem FHOK Clinic
Less direct forms of birth control sabotage involved sabotaging women’s scheduling of visits to clinics to receive FP. In the excerpts below for example, FP clients describe their clinic books (which help them remember their FP appointment dates) being destroyed, and some of the strategies they employ to keep their clinic cards in creative places away from their husbands.

“There is a neighbor who was using injectables that last for three months, and there was a time that she left for church, and upon the husband searching the house, he found her clinic book in her suitcase. He tore the clinic card into pieces when we got back from church.”  
-FP Client, Kibera FHOK Clinic

"There is a lady who told me that she hides her card in the Charcoal bag because the man would never think it is there and you see the injection, it is very difficult to know whether the lady is using."  
-FP Provider, Eastleigh FHOK Clinic

**Limiting Contraceptive Choice**

There were additional partner behaviors and messages that limited or hindered women’s choices regarding use of contraception and contraceptive method. Beyond pregnancy coercion, birth control sabotage, and pregnancy pressure there were other partner-specific barriers that hindered women’s attempts to use contraception. For example, male partners had many myths and misconceptions about family planning use. One prominent male theme was the sentiment that family planning may affect long-term fertility such as barrenness or deformities in children.

Cultural constructions of marriage as being primarily for procreation are also used to hinder women’s use of family planning. Some women spoke of messages conveyed to them about pregnancy prevention or contraception being only a concern of ‘prostitutes,’ who were sexually active for commercial purposes, rather than for the purposes of planning a family.

A major partner-specific barrier involved men’s perceptions of how family planning negatively impacts their sexual experience with their female partners. Women spoke repeatedly of their partners’ complaints about their being ‘cold’, i.e., having little interest in sex (perceived to be a result of using injectables), about the increased length of their menstrual period and how this...
reduced the number of days that she was available for sex, and about particular methods that they perceived to negatively affect their sexual experience (e.g., feeling the string of an IUD).

“But right now, I am using the coil. It created problems for me because [my husband] used to say he could feel it, and also it lengthened the duration of my period. Before, he would wait for only two days, but now, he has to wait for a long time for me to finish my period. During my period days, we don’t talk to each other – to the point that our children noticed. And, you know, you cannot tell them why you’re not talking to each other. This makes one very uncomfortable with the contraceptive one is using.”

- FP Client, Jerusalem FHOK Clinic

“In that case I will give an example, as I had said, about that family planning injection, my husband does not want it, and I do it secretly, because it makes me cold... As in, I do not feel like sleeping with a man, I completely do not feel like [it]. I can stay even for two or three months without having sex, it gets to a point it causes violence; that is the reason why he does not allow me to use that injection, which makes me go for it secretly.”

– FP Client, Jerusalem FHOK Clinic

At times, respondents stated that partners only supported the use of certain FP methods. Women reported that their male partner’s strong opinions about method choice prevented her from using her preferred method and/or was forced to use the preferred method of her partner.

“...Most men let me say like mine, he does not want the pills at all, there is something he suggested that I did not like at all...He was telling me norplant, and me I am scared of that one.”

– FP Client, Jerusalem FHOK Clinic

“The best example is of the pill. You know when using the pill, you can stop at any time; or if you are using the coil, you can also remove it. But if you are using the injection, you have to wait until its time elapses. So in their case, they rushed for the injection, which has its side effects...”

– FP Client, Jerusalem FHOK Clinic

Some respondents also told stories of partners or family members (mostly in-laws) pressuring them to use traditional contraceptive methods.
“I have a friend whose mother asked her not to use modern contraception, but to use the traditional family planning methods. So she has been using traditional herbs, but that has not worked in her favor, as she is on her third pregnancy as we speak. I have tried to talk to her, but her mother has been persistent that she uses the traditional herbs.”

–FP Client, Eastleigh FHOK Clinic

“There is a friend of mine whose husband has denied her the use of modern contraception, insisting that they are also affecting him as a man, and he has been asking her to use traditional herbs because they are versatile. In addition to helping her prevent pregnancy, they were also helping in cleaning out her system.”

–FP Client, Eastleigh FHOK Clinic

B. Women’s Coping Strategies

A key question given the prevalence of RC in the narratives of women seeking contraception is how women cope with coercion and manage to use contraception despite their circumstances. Findings show that women devised several coping mechanisms for mitigating reproductive coercion. The coping mechanisms involved four main areas, namely: clinic visits without partners’ knowledge, relocation of method or clinic card, method-switching, and peer support.

**Clinic Visits and Scheduling Without Partner Knowledge**

Women’s strategies to visit clinics without partners’ knowledge included visiting the FP clinic when their partners were away, or combining their FP clinic visits with some other activity their partners found acceptable (e.g., fetching water, taking out the trash, or taking a child for a clinic visit) in order to deflect attention from their possible FP use. Other related practices included using fake names on clinic cards and calendars to eliminate suspicion. Women reported hiding their family planning clinic reminders (from cards/calendars to phone). Some women also chose unconventional hiding places for their clinic cards in attempts to overcome barriers to their use of family planning.

“I used to go secretly because I was not ready to get pregnant then. ... You wait until your partner is not around, and rush to the nearest clinic, get an injection, and hide the clinic card.”

–FP Client, Jerusalem FHOK Clinic
“I would pretend that I was taking my child to the clinic, and instead would go to see a doctor dealing with family planning services.”

-FP Client, Jerusalem FHOK Clinic

“There is a neighbor friend of mine whom I referred here to FHOK, but she still does not want her husband to know. So when she comes for the service, she does not want the husband to know, so she tells the service provider not to give her the card, but she marks the return date on the calendar at home, as if it is a reminder about her Chama [women’s savings club meeting].”

-FP Clients, FGD, Kibera FHOK Clinic

“There is a neighbor of mine who keeps the [clinic] card in the house, but her name does not appear on the card. She has a Luhya name on the card, whereas she is a Kamba. So there is a time that the husband came across it, and she said that it belongs to a neighbor as the names are different.”

-FP Clients, FGD, Kibera FHOK Clinic

“There is a friend of mine whom I introduced to family planning methods and she was afraid of her husband getting to know and I accepted [to keep her card for her], but she seems smarter than I am as she keeps the card herself nowadays. ... [S]he told me that she is the one who cleans her husband’s shoes and so she slots the card in her husband’s in-sole, so when she cleans the shoe, she checks her clinic return date [laughter]. So she goes to the clinic when her husband has gone to work. When she comes back, she slots it back in the husband’s shoe for him to carry it for her.”

-FP Clients, FGD, Kibera FHOK Clinic

**Hiding Family Planning from Partners**

Respondents also provided accounts of hiding their family planning method in a location unknown to their partner, keeping the method with a friend, or relocating the storage site of their method (e.g., from the home to the office).

“My sister in law started using pills but till in secrecy, because for her she did not want a child. Now the husband was working far away from home, and it reached a time he called her that he was coming home-- and remember she was using these pills in secret. So she had kept these pills under the mattress. So it got to that day when he was coming, you know the way us women organize ourselves when your husband tells you he is coming; when he is coming you have to organize yourself.”

–FP Client, Jerusalem FHOK Clinic
“She loves chewing, so she tells me the sweets that are kept in small containers, he doesn’t chew, she told me that she was going to put them in there and mix them and he will just know that they are sweets but only her will know that they are family planning pills in there…”

–Provider, Jerusalem FHOK Clinic

“That is tricky because when they come, most of them prefer a family planning method that their partner will not notice. So this one limits them to injectable and for those who use pills, some tell me that they swallow these pills at their friend’s houses that is where they keep them. They keep the pills in their friend’s houses not in their own houses.”

–FP Provider, Kibera FHOK Clinic

**Method-switching**

Women were often obligated to switch from their preferred method of birth control to another, less detectable method (often, the injectable) in order to circumvent reproductive coercion by their partners. Providers were often helpful and necessary in shepherding women through this process.

“So I talked to the doctor secretly, and after removing the implant that I had, I started using the injectable, and that is what I am using to date – but without [my husband’s] knowledge.”

- FP Client, Kibera FHOK Clinic

Some respondents discussed experiencing side effects perceived to be related to their FP method that became noticeable to their partners, who, in turn, suspected they were using a method. To prevent their male partners from suspecting their FP use from visible side effects, some women reported constantly trying to hide the side effects they were experiencing by repeatedly changing FP methods.

“For me I wanted to do family planning because I already have enough children, you know when you give birth, you have to do it with some plan, and now my husband knew I was using pills and he completely refused, he told me that during intercourse I was becoming so wet and watery…, it is as if he realized I was using the pills… so he refused that method and started quarreling, it is like he knew, so I just decided personally to change the method to avoid the fights, so I just decided to go for the injection. Right now I use injection but it equally does not treat me well, you find that he has the urge for sex, while I do not, I do not even have the strength leave alone the urge…That I think is what is bothering him the most; he
does not want FP completely. And you see me when he asks me what I am using I say there is nothing I am using, because if I tell him that will be a problem.”

– FP Client, FHOK Jerusalem Clinic

**Peer Support**

Many female FP clients relied greatly on support and encouragement from other women in order to achieve their pregnancy prevention goals. Respondents were often introduced to family planning by friends who took them to the FP clinic for the first time. Other women reported getting help from friends who kept their birth control pills or clinic cards for them so that they could maintain their use of FP. Importantly, *Chamas* [women’s saving clubs] provided an important platform for information and support around FP use, and emerged as a major theme.

“My friend started off with pills – the ones that you get in three-month batches – just like I did. But her husband noticed as she used to take home many pills so that she didn’t have to go to the clinic frequently. So her sister-in-law saw her taking the pills, and told her husband to go and check his wife’s hand bag, and that is when the husband threw the pills away, and that is when the Chama women told her to stop using the pills and start using injectables, as that’s difficult for anyone to notice.”

- FP Clients, FGD, Kibera FHOK Clinic

“I am even the one who keeps the pills for [my friend] because she cannot keep the pills in her house, as she is not yet married. She is seeing men [sexually active], but she doesn’t want to get pregnant, so I have advised her to use pills and condoms.”

- FP Client, Kibera FHOK Clinic

**C. Opportunities for Providers to Support Women Experiencing RC and IPV**

Interviews with family planning providers, clinic managers, and family planning clients, revealed many examples of providers responding to and addressing FP clients’ needs around RC. Additionally, and just as informatively, participants shared providers’ strategies and approaches to dealing with RC that were less helpful to FP clients. These experiences and observations help identify opportunities to improve client-oriented support for women experiencing RC among FP providers.
Respecting Clients’ Right to Autonomy over Family Planning Decisions

Clients and providers noted the importance of respecting female clients’ choice regarding whether they wanted to use a family planning method and, if yes, which type (regardless of her male partner’s preferences). Multiple opportunities for providers to demonstrate this respect were described. First, clients preferred that providers take extra time to understand the context around their FP decision and withhold judgement over their choice to use FP without a male partner’s permission. Second, providers who worked with clients to develop strategies for them to use an FP method without her male partner knowing were reported to be very helpful. Some providers did this by suggesting FP methods that a husband would be less likely to detect, while others allowed her to keep her clinic card at the clinic rather than requiring her to take it home. Other providers even deceived client’s husbands to ensure women were able to use a method and their method of choice. This was especially true if partners were present at the clinic and there were disagreements about method use and choice. Two examples included husbands who adamantly insisted that the client’s IUD be removed. In these cases, the providers removed the IUDs and showed the husband as evidence, but during the procedure either inserted a new IUD or gave the client an FP injection based on her privately disclosed preference to keep using FP.

“...[My husband] took me to the health facility and instructed the doctor to remove the implant from my arm. Before I was taken there – I spoke to the doctor before the Norplant was removed. But I had already spoken to the doctor about what I was going through, so the doctor gave me an injection that lasts for 3 months. So my husband thinks that I’m not using contraception, and that’s what I am still using to date.”

– FP Client, Kibera FHOK Clinic

Without the opportunity to consult privately with the client without the male partner present, it would have been challenging for the providers to know the true preferences of the client.

Supporting Clients’ Right to Confidential Health Care

In addition to the need to ask clients their family planning preferences separate from the husbands, clients and providers reported that maintaining client confidentiality can be challenging in the context of FP services, yet is very important for clients to feel comfortable accessing family planning services. Clients reported that one of the primary barriers to them seeking family planning
services or disclosing RC would be fear that the provider would tell their male partner, family, or other community members, especially if the provider knows the client’s family or is from the community.

“You see, we live in the same estate, and when I come to this place, [a provider at the facility] knows me, and chances are that she knows my husband. So when I go to the facility, and Phyllis provides me with the family planning services, Phyllis might tell her husband, and then her husband goes and tells my husband that I am on family planning – yet, you were doing these things privately. Maybe my husband does not want [me to use family planning]. You see? This will turn into a fight in the house. That is the reason why you will find someone going as far as Kenyatta [National Hospital] because they don’t want to be spotted.”

– FP Client, Kibera FHOK Clinic

These reports suggest that confidentiality policies may not be clear to clients, and in some cases to providers. Providers gave other examples of experiences in which angry husbands came to the clinic demanding to know if the provider gave their wife a FP method. Sometimes these situations felt unsafe or intimidating to providers, especially in the context of clinics located in communities marked with high levels of violence. Often they felt compelled to reveal the clients private medical information. While these experiences do not seem common, they stress the importance of equipping providers with strategies and tools for maintaining client confidentiality that also account for and ensure their safety.

**Offering to Provide Male Partners with FP Education If Desired By Client**

Clients and providers emphasized that sometimes male partner resistance to the clients’ use of family planning comes from their lack of understanding of FP and the misconceptions regarding long-term fertility effects. In these scenarios both clients and providers mentioned that education from providers might facilitate discussion about FP between women and their male partners because they are more likely to believe information coming from providers than women themselves.

“There are so many challenges these people are facing. I have been in slum communities, mostly. They have many challenges. Like, some come, and when you explain family planning methods to them, they say, ‘My husband doesn’t like this
because of infertility.’ ‘When you take family planning methods, you won’t give birth.’”

–FP Provider, FHOK Clinic

“There are those who are afraid to open up to the doctors or family planning service providers for that reason because they have believed in what they have been told either by their partners or any other family member that contraceptives would render them infertile, sexually inactive, or susceptible to having children with abnormalities.”

–FP Clients, Kibera FHOK Clinic

Male engagement was the most suggested tactic by both providers and clients. Many respondents recommended or noted positive experiences when providers met with both partners together to provide FP counseling. Specifically, respondents stated education from providers may help husbands improve their acceptance of and cooperation with family planning.

“…the doctor sat us down and explained to us the best type, and [my husband] agreed...He used to tell me that my body was ‘cold’ and he did not enjoy making love to me, and at times thought that I was having affairs with other men. But after the doctor explained things to him, we resolved our issues amicably.”

– FP Client, Jerusalem FHOK clinic

While it is critical to note that such partner engagement will not be a safe option for many women experiencing RC and/or IPV, and that any such approach must be optional and voluntary on the part of women, this may be a helpful strategy for some female clients. One potential strategy outside of clinical care to promote male engagement that was suggested is for husbands/partners supportive of FP to speak to other husbands/partners who disagree with FP and teach them why they think it is a positive practice in their relationships.

**Offering Referrals to IPV Services**

Few experiences were shared about referring clients to IPV survivor services, despite multiple situations in which clients disclosed IPV. This indicates an important gap in linkage to services; we hope to address this gap via the adapted intervention.
IV. CONCLUSIONS - Key Points for Adaptation

These formative research data provide a strong foundation for the adaptation of the ARCHES model to the Kenyan context. The unique forms of RC and helpful coping strategies clients disclosed provide appropriate content for the adaptation of screening questions, pamphlet content, and vignettes (i.e. model scripts for providers implementing ARCHES intervention). The harm reduction strategies that providers suggest to clients for each family planning method will be developed based on the coping strategies clients shared. For example, a harm reduction strategy that a provider might suggest for using birth control pills without a husband knowing may include hiding these at a friend’s house or in a place a male partner is unlikely to check. Such context-specific examples from clients and providers from FHOK clinics will infuse relevant locally-informed strength into the adaptation of the intervention.

Based on these formative data, protocols will be developed for maintaining client confidentiality and creating a policy to allow safe and private counseling and assessment, especially when clients are accompanied by partners resistant to allowing her privacy (this was not a factor in the context of the original ARCHES implementation). At the same time, the desire to include male partners in FP counseling and education, when safe, was clearly expressed in the formative data indicating that adding such a component to the ARCHES intervention may be helpful. As discussed above, this will need to be developed carefully in order to ensure safety and client-centered care. Finally, a context-specific protocol for linking FP clinical services to IPV survivor services will be developed that facilitates client access to survivor services and reduces associated stigma for the client, while also easing providers’ perceived burden and stress associated with providing such referrals.