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RESEARCH ARTICLE

Factors influencing women's decisions regarding birth planning in a rural setting in Kenya and their implications for family planning programmes

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Abstract

Evidence suggests that socio-cultural barriers that limit the ability of women in sub-Saharan Africa to make decisions regarding contraceptive use and childbearing contribute to the slow uptake of contraception in this region. This paper explores factors influencing women's decisions regarding contraceptive uptake, switching and discontinuation, and the implications of those decisions for family planning programmes. Data were from in-depth interviews that were conducted in 2018 with 42 women who participated in a longitudinal research project implemented in Homa Bay County of Kenya. Participants comprised women who were aged 15–39 years at the time of recruitment into the study and who discontinued using injectables or implants between the first and second rounds of data collection. Data were analysed using an exploratory inductive content analytic approach. The findings show that uptake of contraception was largely driven by concerns about the negative consequences of frequent childbirth on individual health and household socioeconomic well-being. Most women discontinued methods because of dissatisfaction but, instead of abandoning contraception altogether, switched to alternative methods, albeit sometimes less-effective ones. However, some women had difficulties in identifying an appropriate new method after experiencing side-effects, contraceptive failure or stock-out of their current method. Securing the cooperation of sexual partners was an additional problem especially for women whose partners did not support contraception. The findings suggest that concerns about the negative consequences of frequent childbirth outweigh challenges associated with contraceptive use. This presents an opportunity for family planning programmes to improve contraceptive uptake and continuation by addressing the health system challenges related to commodity stock-out and poor quality of care, as well as the concerns of men.

Keywords: Contraceptives; Decision-making; Rural Kenya

Introduction

The 1994 International Conference on Population and Development (ICPD) shifted the focus on sexual and reproductive health (SRH) from a demographic to a human development perspective and recognized SRH as an essential element not only of good health but also of the realization of national and global development goals (UN/DPI, 1995; UNFPA, 2004). The ICPD Programme of Action emphasized the rights of women and men to reproductive choice and to safe and affordable SRH services (UN/DPI, 1995; UNFPA, 2004). The rights-based approach to SRH was also a key focus of the 1995 Beijing Declaration and Platform for Action – adopted during the United Nation's Fourth World Conference on Women – which reiterated the rights of women to freely and responsibly make decisions regarding their SRH (United Nations, 1995). More recently, the

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international community made a commitment during the 2012 London Summit on Family Planning to secure and fulfil the rights of additional 120 million women and girls in the world's poorest countries to access comprehensive contraceptive information and services by the year 2020 (FP2020 Rights and Empowerment Working Group, n.d.). Additional countries made commitments during the 2017 Summit (FP2020, 2017).

The rights-based approach to SRH requires policies and programmes to ensure that: 1) services are available, accessible, acceptable and of good quality; 2) users are empowered to demand and use the services, and have the autonomy to make informed choices; and 3) there is equity, transparency and accountability in the provision of services (FP2020 Rights and Empowerment Working Group, n.d.; UNFPA, 2010; CESCR, 2016). In the context of family planning, a rights-based approach further aims to empower individuals to make their own decisions about whether, when and how many children to have (FP2020 Rights and Empowerment Working Group, n.d.; Hardee *et al.*, 2014). The approach, if well operationalized, should ideally lead to strengthened ability of poor and vulnerable populations to demand and use SRH services and information. There are, however, ambiguities regarding what the approach entails in different contexts, which are compounded by the existence of varied frameworks and guidance on its key elements and operationalization (Gruskin *et al.*, 2010; Kumar & Hardee, 2017). These challenges are likely to be more profound in resource-constrained settings such as sub-Saharan Africa (SSA) where poverty, fragile health systems and the socio-cultural environment may confound the successful implementation of rights-based SRH programmes.

With respect to family planning, persistent doubts remain about the prevalence and strength of demand for contraception in SSA. Evidence of such demand mostly comes from quantitative measurements of unmet need (unmet demand) and current use (met demand) of contraception based on estimates from the Demographic and Health Surveys (DHSs). Estimates show that SSA lags behind other regions in contraceptive uptake and in meeting the demand for contraception (Fabic *et al.*, 2015; UNDESA, 2015). For instance, contraceptive use among married women is much lower in Africa (36%) than in other regions of the world where use ranges from 58% in Oceania to 75% in North America, Latin America and the Caribbean (UNDESA, 2017). Unmet need for contraception among married women is also highest in the region (23%) compared with other regions such as the Caribbean (19%) and Asia (13%) (PRB, 2019). The patterns in SSA have partly been attributed to socio-cultural barriers that limit the ability of women to make decisions regarding contraceptive use and childbearing, as envisioned in the rights-based approach (DeRose & Ezeh, 2010; Darteh *et al.*, 2019).

Contraceptive discontinuation presents additional challenges to realizing the goals of rights-based family planning. Estimates show that 32% of women with unmet need for a modern method in SSA had used such a method in the past but discontinued use (Jain *et al.*, 2013). Most women who discontinue use when they are still in need of protection do so for method-related concerns, including experiences of side-effects, health concerns and contraceptive failure (Ali *et al.*, 2012; Castle & Askew, 2015). In spite of this evidence, decisions by individuals and couples regarding contraceptive uptake and discontinuation in low-income settings are poorly understood. This has partly been attributed to lack of robust longitudinal quantitative and qualitative data that allow an in-depth understanding of decisions by individuals and couples in such settings (Castle & Askew, 2015).

This paper uses data from a qualitative study that was nested within a longitudinal research project in Homa Bay County of Kenya to explore factors influencing women's decisions regarding contraceptive adoption, continuation, switching to another method or abandoning use altogether. Understanding the factors influencing women's sequential contraceptive decisions is, in turn, important for informing strategies to support existing and new users.

Conceptual and contextual background

Studies show that contraceptive use among women in SSA varies by individual-level factors such as age, education level, religious affiliation, parity, work status, spousal communication and

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attitudes towards contraception (Blackstone *et al.*, 2017; Bahamondes & Peloggia, 2019; Olakunde *et al.*, 2019). Contraceptive use further varies by contextual factors such as place of residence, access to family planning information and services and socio-cultural norms around gender roles, fertility and family planning (Blackstone *et al.*, 2017; Mutumba *et al.*, 2018; Bahamondes & Peloggia, 2019; Olakunde *et al.*, 2019). Thus, contraceptive use is likely to be high in contexts where these individual and contextual factors favour greater decision-making autonomy for women and where appropriate services are readily available and easily accessible (DeRose & Ezeh, 2010; Bahamondes & Peloggia, 2019; Darteh *et al.*, 2019). However, how women in low-income settings navigate through individual contraceptive decisions is less understood.

The study setting, Homa Bay County, is located in south-western Kenya in Nyanza region along the shores of Lake Victoria and has an estimated population of 1.13 million people (Republic of Kenya/Homa Bay County Government, 2018; KNBS, 2019). The total fertility rate (TFR) for the county is 5.2 children per woman, which is slightly higher than the average of 4.5 children per woman for rural areas (KNBS *et al.*, 2015). Forty-seven per cent of the women in the county use any method of contraception, which is lower than the average of 56% for rural areas (KNBS *et al.*, 2015). A similar pattern occurs for use of modern methods – 46% in the county compared with the average of 51% for rural areas (KNBS *et al.*, 2015). In addition, Homa Bay has the second highest prevalence of teenage childbearing (22%) and the highest HIV prevalence (20%) in the country (KNBS *et al.*, 2015; NASCOP, 2020).

The unfavourable SRH indicators in the county have partly been attributed to poverty and socio-cultural practices that increase exposure to risky sexual behaviours such as early marriage, polygamy, widow inheritance, exchange of sex for fish with fishermen and night dances organized during funerals to appease the dead (Juma *et al.*, 2014; Otieno & Okuku, 2017; Republic of Kenya/Homa Bay County Government, 2018). The situation is further exacerbated by the patriarchal nature of the society – a system that perpetuates gender gaps that favour men while restricting opportunities for women to make decisions regarding their sexuality, health and socioeconomic well-being (Anunobi, 2002; Madiba & Ngwenya, 2017). In such a context, women's ability to freely decide whether, when and how many children to have may be greatly limited. Understanding the factors influencing their reproductive decisions under such constraints is important for informing strategies to promote their SRH rights and outcomes.

Methods

Data were from in-depth interviews that were conducted in 2018 with 42 women who participated in a longitudinal research project implemented in Homa Bay County of Kenya. Women were recruited into the longitudinal research project in November–December 2016 (Round 1) and re-interviewed in October–November 2017 (Round 2) and August–September 2018 (Round 3). The goal of the project was to generate evidence on retrospective and prospective measurements of unintended pregnancy and its outcomes as well as reasons for contraceptive non-use. The project targeted married or cohabiting women aged 15–39 years at the time of recruitment in three sub-counties of Homa Bay County (Ndhiwa, Rachuonyo North and Rachuonyo South). The choice of these sub-groups of women was informed by plans to follow and interview them when they are more likely than unmarried, non-cohabiting or older women to be at risk of pregnancy (Machiyama *et al.*, 2017).

Women were recruited into the project in two stages. In the first stage, twelve sub-locations (the smallest administrative unit in Kenya) were randomly selected in each sub-county. The research team, with the help of the local administration, then identified all households in the sampled sub-locations that had currently married women aged 15–49 years and all individuals in those households were listed to generate the sampling frame. A sample of 3118 currently married or cohabiting women was randomly selected from among 5424 who met the criteria for inclusion

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in the study (i.e. married or cohabiting and aged between 15 and 39 years). Interviews were completed with 2424 women during the Round 1 and 2080 women during Round 2.

In-depth interviews were conducted during Round 3 with a subset of women who discontinued injectables or implants – the two dominant women-controlled methods in the project site – between Rounds 1 and 2. Forty per cent of the women who were using a method in Round 1 had discontinued use in Round 2, with discontinuation being higher for injectables than implants (42% and 20%, respectively). Participants in the in-depth interviews were purposively identified among those who discontinued injectables or implants between the two rounds of data collection. The selected women were stratified by the method they had discontinued (21 for implants and 21 for injectables), major reason for discontinuation (side-effects/health concerns, wanting to become pregnant, contraceptive failure, infrequent sex, desire for a more effective method, inconvenience of use and husband disapproval) and sub-county. The interviews were conducted a few days after participants completed Round 3 survey interviews. The purpose of the in-depth interviews was to understand contraceptive use and provision practices that are likely to influence method discontinuation. The interviews explored women's access to information about family planning before adopting a method, their interactions with service providers when obtaining a method, their experiences with the method and whether and how those experiences influenced their decisions as well as views about the method.

The interviews were conducted in Dholuo (the language spoken in the study site), audio-recorded with the consent of the informants, transcribed and translated into English. There was, however, no back-translation of the transcripts into Dholuo to determine if any meaning was lost in the process. The data were analysed using an exploratory inductive content analytic approach based on pre-determined questions that focused on access to information on the method before initiating use, interactions with service providers when obtaining the method, experiences with using the method, actions taken after discontinuing use and attitudes towards the method in particular and contraception in general based on experiences with use. Analysis specifically focused on participants' responses to the following questions: 1) What informed your decision to use [METHOD]? 2) What informed your decision to stop using [METHOD]? 3) What actions did you take after stopping to use [METHOD] and how did that influence your opinions about [METHOD] in particular and family planning in general? Specific quotes from the interviews are used to support the key insights on factors influencing women's decisions regarding contraceptive uptake, continuation, switching or complete abandonment. The quotes are identified by the age of the women at the time of recruitment in the study, the method they discontinued between Rounds 1 and 2 and the reason for discontinuation.

Results

Characteristics of study participants

Participants in the in-depth interviews were equally distributed across the three sub-counties, with fourteen participants being interviewed from each sub-county. Most of the participants (35 out of 42) were living with their partners while the rest were living away from their partners at the time of recruitment into the study. More than half of the participants (24 out of 42) were aged 25 years or older at the time of recruitment, eleven were aged between 20 and 24 years while the rest were below 20 years. About a third of the participants (15 out of 42) had secondary or higher levels of education, a similar number had completed primary education while 12 had no formal education or had incomplete primary education. Fifteen participants had four or more living children at the time of recruitment, eight participants had only one child while the rest had between two and three children.

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Contraceptive uptake

Women's decisions to take up contraception in this rural community were informed by factors that are consistent with the international discourse relating to the benefits of family planning, including improvements in health, socioeconomic status and individual rights. Participants expressed concerns about the negative effect of frequent childbirth on their health and the health of their children as well as their ability to meet education and other basic needs of children. They noted that giving birth frequently would lead to a deterioration in their own health because the body would not have sufficient time to recover from a previous birth. Some also felt that that they would age faster as a result of frequent childbirth, which may drive their husbands to seek prettier women out of wedlock. Participants further reported that a pregnancy that occurs soon after the birth of a child denies the child an opportunity to breastfeed properly and motherly attention in terms of emotional support. They indicated that children who closely follow each other are likely to pass through the various stages in life (such as schooling) together, which may pose difficulties in meeting their basic needs all at the same time. The decision to take up contraception was also viewed in the context of rights: that is, that contraception helps women to only give birth when they want to. The following excerpts highlight some of these concerns.

> I remember when I first started giving birth I did not use family planning by that time. I gave birth to children without spacing and currently if you look at my first born and the followers, their ages almost look similar like twins. Remember I became pregnant with my first son [second born] when my first born had not yet walked ... this really bothered me and that is what informed my decision to use family planning so that in case I had to become pregnant then this could only happen after I had stayed for some time. (33-year old, implant user – got pregnant while using)

> Family planning ... helps the child to have enough chance to grow before the mother could have another child. Using family planning also helps mothers to space births and only give birth when they want. This is important because they can as well do other important duties aimed at generating income to sustain the family. (30-year old, injectable user – side-effects)

Besides recognizing the need to use contraception to avoid some of the negative consequences of frequent childbirth, women had to make decisions regarding the appropriate method to use, which required having information on the methods. Participants reported that they obtained information on specific methods from relatives, friends, neighbours, health care providers or mass media, which is consistent with what is known regarding the major sources of contraceptive information in the country. Information obtained from these sources sometimes discouraged women from using certain methods. Some participants, for instance, reported having heard of women who died because of using implants or pills, that the intrauterine device (IUD) keeps shifting in the body and may force one to undergo surgery to remove it, and that tubal ligation can cause cancer. When asked by interviewers whether they had personally witnessed such cases, the participants reiterated that they had only heard about them but such information nevertheless influenced their opinions regarding which method to use. Information obtained from health care providers was generally considered useful although some participants reported that it was limited or biased towards a particular method, mostly injectables or implants. However, most participants had decided on a method before attending a facility and the role of providers in such instances was modest. The quotes below illustrate the different experiences of women accessing information on family planning.

> That information [obtained from friends] helped me make a decision given the circumstances I was in at that particular time [exposed to sexual activity four months after the birth of a child] and again at the facility, health providers usually sensitize mothers on the importance

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> of family planning. In the process of sensitization, I gathered courage to use injectables although I was afraid from the beginning. (35-year old, injectable user – partner disapproval)
>
> Information was given in a sarcastic manner by maternity nurse, 'In a modern world like this, where everyone is currently using family planning, why don't you even obtain injectable instead of giving birth when you still have a young child on your lap?' She did not sit me down to give me the information formally. (30-year old, injectable user – side-effects)

Other women were influenced by actual positive or negative experiences of members of their social network (relatives, friends or neighbours) with a particular method, including lack or presence of side-effects and effectiveness of the method in preventing pregnancy. Some women opted for a method if members of their social network had positive experiences with it. Decisions regarding choice of a method were further influenced by what was available at the nearby health facility and costs of obtaining the method (in terms of time, distance and service costs), which is also consistent with other evidence for Kenya. Participants reported that the available options were often limited. Decisions based on cost varied by type of method and individual beliefs regarding what is affordable. Some participants considered obtaining injectables every 3 months to be expensive in terms of time, travel costs and cost of the method (equivalent of US$0.50 on average at facilities that charged) while others did not see such costs as a major obstacle. Similarly, some participants viewed implants as being cost-effective in that it is inserted once, mostly at no cost, and lasts for a long duration while others considered the cost of removal (ranging from US$2 to US$5 depending on type of provider) to be expensive. The following quotes exemplify these varied opinions.

> Another reason I hated injection was because I used to have it at a facility known as [NAME] which is very remote and it costs 50 shillings [equivalent US$0.50] to reach the facility, and I had to pay 50 shillings for the Depo. I felt it was expensive because I had to pay the 50 shillings for transport and 50 shillings for the method every 3 months. Then at times I could not get time to go for the appointments or lack fare so I could default. (25-year old, implant user – side-effects)
>
> I preferred injectables because I could easily remember the return date … I could not forget about the date. In any case, it was indicated in the clinic card because it takes a shorter duration, not like implant that takes a longer duration … I thought I would forget about the return date when using implant because the method took longer duration; sometimes the return date could elapse without my knowledge … You will be required to pay fifty shillings [equivalent US$0.50] before obtaining the method [injectables] at public health facilities. The cost varies with different facilities and providers. (29-year old, injectable user – got pregnant while using)
>
> I wanted a long-lasting method. Making frequent visits to the facility was a problem to me, so I wanted something that could last for a longer period … Initially I knew implant is removed for free but I was charged three hundred shillings [equivalent US$3] during removal; that time public health providers were on strike. (29-year old, implant user – wanted to become pregnant)

Apart from choice of a method, women had to make decisions regarding involvement of their partners in family planning. Twenty-three participants (slightly more than half) reported that their partners were supportive, and in some cases the partners provided financial support or encouraged women to seek family planning services. Partner support was mostly due to concerns about the woman's health or the ability of the household to meet the needs of a large family. In such cases, participants did not experience major hurdles in making decisions regarding whether or not to use contraception. Rather, the key decision for them pertained to choice of an appropriate method. In contrast, nineteen women whose partners did not support the use of

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contraception faced twin challenges of deciding whether or not to use a method and the type of method to use without their partners' knowledge. Those who secretly used contraception were under constant fear of the consequences of discovery, including the potential for violence and being forced to abandon contraception and thus exposed to the burdens associated with frequent childbirth. Secret use of a method sometimes determined where women sought services, with some of them preferring private providers (for quick services) to public health facilities where long waiting times would raise their partners' curiosity regarding their whereabouts. As some participants reported:

> My husband doesn't like me going for family planning and I do everything behind his back. Actually, if he gets to know that I am doing it he can even beat me because he does not want me to use any family planning method. He cannot as much as give me money to go for the service and even when I am using it, I normally save money on my own. (23-year old, injectable user – side-effects)

> I was just hearing them [women in the village] say there is something called family planning and I decided to also try it out because whenever I went for delivery, I could bleed profusely to near death and when I heard there is something like family planning, I decided to go without telling my husband. I just sneaked out of the house and went ... According to the [number of] children I had, I had no choice but to try. (32-year old, injectable user – side-effects)

Contraceptive continuation or switching

Decisions regarding contraceptive continuation or switching were largely influenced by experiences of side-effects, commodity stock-outs or failure of the method and how health care providers responded to these problems. Women who were secretly using contraception against their partners' wishes faced enormous challenges when they experienced side-effects and consequences related to excessive bleeding or low libido as these were conditions that their partners could easily detect. Such women adopted different coping strategies. Some used the pretext of taking the baby for health check-up to get permission from their partners to visit a health facility where they could switch to another method, be counselled on, or be given medication to manage the condition. Others who experienced low libido decided to give in to their partners' sexual advances to conceal their contraceptive practices or to forestall any disagreements which could lead to violence from the partner. In contrast, most women with supportive partners reported discussing with them when they experienced side-effects or low libido. In such cases, the partners advised the women to visit a health facility for assistance, provided money for seeking care, or abstained from sexual activity when the women indicated that they were not in the mood for sex. Some of these experiences are exemplified in the quotes below.

> I cannot deny him sex because it will mean him knowing I am on family planning methods and he doesn't like it so it can cause problems in the house ... I just lie there and let him finish his desires because I am assured of a beating if he knows I am using family planning ... I cannot allow someone to be beating me every time though I am sure I normally have no feelings for him. (23-year old, injectable user – side-effects)

> It is the pain of this fifth baby that drove me to go and try family planning which I did when I took my baby for postnatal care clinic. The doctors took us through the various methods and I chose the three-month injection which started having effects on me almost immediately. I was constantly bleeding and it got me worried because I was using family planning behind my husband's back. I then went back and explained to the doctor what was happening and in turn he injected me and the bleeding stopped. (28-year old, injectable user – side-effects)

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Commodity stock-outs and contraceptive failure, on the other hand, presented a dilemma for women whose partners approved and those whose partners opposed contraception alike. Women who discontinued a method because they wanted to become pregnant mostly sought the same method upon resumption of menses and sexual activity after delivery. Some of these women switched to other methods when the method they were previously using was out of stock. This mostly affected implant users – a method that was mainly available through outreach services conducted in local health facilities every 3 months. However, some injectable users also reported experiencing stock-out of the method in public health facilities, which made them seek services from private health facilities or opt for other methods. With respect to contraceptive failure, the narratives indicated that it was in some cases due to poor screening by health staff rather than the method. Specifically, some women reported discovering that they had been pregnant at the time of method initiation. Such incidents disappointed not only the women but also those partners who approved of contraception. The following excerpts illustrate some of these experiences:

> I used implant until the due date and after the lapse of three years, I removed it here at [NAME OF FACILITY]. That day she asked me to pay for the cost of implant removal, which I did. After removal, I still wanted to use the same method but my effort to reach the provider became futile after several visits to the facility … I made several trips to the facility, almost four good times, before I could decide to use injectables because all appointments with her did not materialize since she was always busy … any time I went to the facility, she could insist that I return the following day; the next day when I returned, she turned me away that she was rushing to a certain meeting. This happened until I lost hope. (23-year old, implant user – lack of access)

> After obtaining the method, I started feeling discomfort in the lower abdomen. Remember I had a small baby by that time. After that I went back to the facility for further check-up. When I explained to them, I was told, 'Maybe you were involved in strenuous activities,' and I asked them, 'Me, I have not been involved in any heavy duty, I don't even go to the *shamba* [garden], so what is the problem?' After staying for something like five months, I went back to [NAME OF FACILITY] where pregnancy test result showed I was five months pregnant. Although I used to feel something like foetus playing in the womb, I was not sure about that because I was already using injectables … Imagine I was using injectables when I became pregnant. (29-year old, injectable user – got pregnant while using)

Women's narratives further indicated that, regardless of the reasons behind contraceptive switching, they faced challenges with identifying an appropriate method that works for them. One participant reported that she asked health care providers whether they conduct medical examinations to determine which method is appropriate for an individual and she was informed that they do not because there was no functional laboratory. The participant was instead told that women are given the methods they ask for. Another participant described the process of identifying an appropriate method as trial and error. This was also evident from the experiences of some women who had tried both injectables and implants but found both unsatisfactory and thus had little alternative but to opt for less-effective methods like condoms or rhythm, which depend on the partner's cooperation. Although some women reported that pills were available in some of the health facilities, there was generally a negative attitude towards this method. Participants particularly expressed concerns about the difficulties of daily adherence, the possibility of being discovered by partners among those secretly using contraception, and the chances of pills forming fatal lumps in the lower abdomen. Many of the participants also still wanted to have children in future. Tubal ligation was therefore an option only for the few who felt that they had enough children and wanted to stop giving birth. Some participants narrated their experiences, thus:

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> At first, I tried injection but then I started bleeding a lot, so I went and told the nurse who told me that other than injections, there were other methods of family planning. So, I went for implant which also affected me … I can only say that I and my husband have decided to stop getting children because the six are enough and I would want to go to [NAME OF FACILITY] to talk to a doctor who can do for me the tubal ligation because taking care of these six may be a problem, prompting the need to stop at this point. (35-year old, injectable user – wanted to become pregnant)

> I stopped using the method because I became pregnant when using the method. In fact, it did not help when I needed it most … It changed my opinion towards the method and family planning in general because I remember one of my friends also became pregnant when using coil, another woman also became pregnant with tubal ligation, and again personally I became pregnant when using implant. After that, I saw no need of using implant and family planning in general … We opted for rhythm method and could only engage in sexual activity during safe days with my sexual partner without using these family planning methods. (32-year old, implant user – got pregnant while using)

Complete abandonment of contraception

Decisions to completely abandon contraception, including use of less-effective methods like rhythm, were rare and only one woman among the 42 who were interviewed reported resolving never to use a family planning method again. Three other women expressed complete disillusionment with contraception either because of side-effects or contraceptive failure. However, one of them opted for rhythm, another reported considering using the same method (rhythm), while the third indicated that she would resume contraception in future although she had not decided on the particular method to use. The one participant who resolved not to use contraception again was using injectables without her partner's knowledge and when she experienced excessive bleeding, her partner took her to the health facility where he learnt that she was using contraception, became angry, and warned her of separation should she use contraception again. This warning, coupled with the health care provider's advice to stop using contraception for a while, made her lose trust in the methods and to resolve to stop using contraception altogether in order to avoid marital disruption. As the participant narrated:

> I was bleeding heavily when I went to the hospital … Blood was oozing as if I was securing abortion and you see something like that, my husband had to notice. Although I was using the method without his knowledge, it was a dangerous and sad experience with injectables … Those side-effects, especially heavy bleeding, affected my opinion towards the method and family planning in general and in fact I lost trust in using these methods … You see, I had to listen to the provider's advice [to stop using the method for a while] … that is how I lost hope in family planning given that my husband had also threatened me with separation in case I continued with the method in future. So, it was a difficult choice to make because I thought it was embarrassing to discuss family planning with parents in case of separation especially when the partner is called upon by my parents to explain further the reasons for separation. Truly, he was angered given that he spent a lot of money on my treatment. (32-year old, injectable user – side-effects)

Discussion

Qualitative findings in this paper show that, despite barriers to decision-making autonomy, there is widespread demand for contraception among women in the rural community in Kenya where the study was conducted. The demand is largely driven by concerns about the deleterious effect of

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frequent childbirth on individual health and household socioeconomic well-being, which conforms to the international discourse on the value of family planning. These concerns propel women whose partners oppose family planning to secretly use contraception. The demand is also evident from the finding that once women take up contraception, very few abandon it altogether. Rather, most women who discontinue a method because of dissatisfaction try other methods even if they are less effective. The findings are consistent with those of a qualitative study conducted among low-income urban women in Kenya which showed that childbearing decisions were influenced by concerns about the health of the mother and child, the cost of raising children and the nature of the relationship with the sexual partner (Towriss *et al.*, 2020). The findings suggest that concerns about the negative consequences of frequent childbirth among women in low-resource settings in the country outweigh challenges associated with contraceptive use. This presents an opportunity for family planning programmes to improve contraceptive uptake and continuation in such settings by addressing the health systems defects pertaining to commodity stock-out and poor quality of care as well as the concerns of men.

The findings of the paper further show that a major challenge for some women in the study setting pertains to identifying an appropriate method after experiencing side-effects, contraceptive failure or stock-out of their current method as well as securing the cooperation of their partners if they are opposed to contraception. Partner cooperation presented a unique problem to women secretly using a method when they experience side-effects or consequences like excessive bleeding or low libido, which could easily be detected by their partners and expose them to the risk of violence or marital disruption. Although the demand for contraception exists in the study setting, decisions regarding whether to use a method and which method to use are complex, especially when women face method- and partner-related barriers. Estimates based on current use or non-use of a method to measure satisfied or unmet demand for family planning – although useful for monitoring the performance of family planning programmes – mask nuances of individual experiences and erroneously equate current use with satisfied use. This verdict is consistent with those from quantitative data that show that high levels of contraceptive use in the study setting exist alongside widespread misgivings about the methods (Machiyama *et al.*, 2018; Odwe *et al.*, 2019). In particular, available evidence depicts a contraceptive 'culture' in the study setting that is characterized by considerable fear and misgivings about methods, coupled with high levels of discontinuation, but widespread need for family planning (Machiyama *et al.*, 2018; Odwe *et al.*, 2019). Some of these obstacles can be addressed by better counselling of clients although the evidence for the effectiveness of this approach is thin. Nevertheless, in the spirit of the rights approach, women should be informed that they might experience side-effects, that these side-effects are usually not a serious health risk, that treatment is available and that method-switching is also possible.

Variations in the use of modern contraceptive methods between counties in Kenya show an *S*-curve distribution, with counties falling in five different phases of the curve beginning from the bottom where there is very slow growth of use of the methods, followed by phases characterized by commencement of acceleration, rapid, slow and plateauing of growth, respectively (Owino *et al.*, 2017). In the *S*-curve distribution, Homa Bay falls among the counties where the growth in uptake of modern contraception is slowing down. The findings of this paper suggest that this could partly be due to method- and partner-related factors, and the shift to less-effective methods like rhythm rather than complete abandonment of contraception. An important consideration for Kenya's family planning programme is then how to use opportunities created by the prevailing demand for contraception in counties such as Homa Bay to ensure that services adequately meet the needs of users. In particular, the findings suggest that besides ensuring commodity security and improving quality of care, women need cooperation of their partners and support to manage side-effects when on contraception. This is consistent with the principles of client-centred approach to family planning programming, which goes beyond clinical quality of care to incorporate support, respect and autonomy of clients (Walle & Woldie, 2017; Diamond-Smith *et al.*, 2018).

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The results have certain limitations. First, the qualitative study was based on a purposively identified sub-set of women who discontinued either injectables or implants between the first and second rounds of the longitudinal study. This restriction thus omits the perspectives of continuing users of these two methods, users of other methods and non-users. In addition, due to resource limitations, the study did not interview the women's partners to determine their views regarding factors influencing women's decisions regarding family planning. Second, the evidence of widespread demand for contraception in Homa Bay may not apply in other settings in Kenya, especially in areas where contraceptive use still remains very low, such as in the north-eastern parts of the country. However, findings from a study in a low-income urban setting in the country show that childbearing decisions are influenced by the same factors that drive the demand for contraception in Homa Bay (Towriss *et al.*, 2020). This is an indication that the findings may be relevant in contexts where use of contraception has taken root. Third, given the lack of back-translation of the transcripts into the language of interview, it could be that some meanings were lost in the process of translation into English, which may affect the interpretation of experiences of the women in the study.

In spite of the limitations, the findings show that even in settings where there is demand for contraception driven by concerns about the negative consequences of frequent childbirth on individual health and socioeconomic well-being, women on contraception need support to overcome method- and partner-related challenges. In particular, the findings suggest that adequate counselling and support from health care providers as well as partner cooperation enable women cope with side-effects and consequences of using contraception.

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