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Family planning in the Eastern Democratic Republic of the Congo: personal beliefs, intimate partner negotiations and social pressure

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ABSTRACT

The Democratic Republic of the Congo (DRC) has a low prevalence of family planning use. Recent studies have highlighted the significant role that socio-cultural factors play in the decision to use family planning or not. This qualitative study explored barriers to women's use of family planning methods in an ongoing conflict region, South-Kivu, DRC. Focus group discussions and individual in-depth interviews were conducted to understand perceptions and habits regarding family planning. An inductive approach was used to analyse the data. Precariousness of life, religious beliefs and fear of side effects were limiting factors to the use of family planning. Power relations within the couple also played an important role in decision-making. Sole provider ('breadwinner') women were more likely to use family planning, including hormonal methods. Our findings highlight the continued importance of family planning programmes that respond to socio-cultural factors, personal beliefs, and fear of side effects in parallel with addressing availability and accessibility. This will require including the community in their design and implementation in order to meet unmet family planning needs. Health care providers' capacity building and training to help women manage family planning side effects will also be beneficial.

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Introduction

Family planning can help maximise available resources in households and communities, thereby contributing to the reduction of poverty in sub-Saharan Africa (Cleland, Ndugwa, and Zulu 2011; Starbird, Norton, and Marcus 2016). Reducing unplanned pregnancies can also be a key factor to reducing maternal and under-five child mortality (Kwete et al. 2018; Mukaba et al. 2015). In contexts of high migration and displacement, having children helps people perpetuate their culture (Ezembe 2009;

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Gendre 2011). In the DRC, children are often viewed as 'wealth' (Dumbaugh et al. 2018) and as a form social security – or they can be a 'burden' when household resources cannot stretch to provide minimum standards of living such as a healthy diet or education (Dumbaugh et al. 2018; Kabagenyi et al. 2016; Muanda et al. 2017). Family planning programmes aim to increase the availability of family planning methods by encouraging uptake supplying health centres with commodities (Babazadeh et al. 2018; Casey et al. 2009, 2019). Many studies evaluating such programmes have shown an increase in family planning demand and the utilisation of health facilities (Babazadeh et al. 2018; Casey et al. 2009, 2019) as result of such actions.

The Democratic Republic of the Congo (DRC) is a central African country with a high rate of fertility. The South-Kivu region of the country has a particularly high rate of 7.6 average births per woman (Institut National de la Statistique (INS) 2019), although health facilities supported by non-governmental organisations in the region readily offer contraceptive services (Casey et al. 2017; Kayembe et al. 2015; Kwete et al. 2018). In South-Kivu, the prevalence of modern contraception was shown to have increased to approximately 36.2% in a recent study (Bapolisi, Bisimwa, and Merten 2023) compared to the 2014 DRC DHS data in which 7.8% women reported using modern contraceptives (EDS 2014). Additionally, the country level of the unmet need for family planning remains high at an estimated 28.7%, 14.1% of which is in South-Kivu (Institut National de la Statistique (INS) 2019).

Existing research from the DRC shows that reluctance to use family planning methods derives from a number of social barriers e.g. socio-cultural norms valuing high fertility and/or lack of partner support for family planning use (Kabagenyi et al. 2016; Matungulu et al. 2015; Muanda et al. 2017). Additionally, religious and church leaders have been found to negatively influence individuals and couples' uses of family planning (Izale et al. 2014; Kaniki 2019). Women in rural DRC tend to favour family planning compared to men because of difficulties experienced during pregnancy (Muanda et al. 2017). Although men are major household decision-makers, women are increasingly material providers for the family in the South-Kivu region (Hilhorst and Bashwira 2014), making them torn between personal convictions, the demands of daily life, and negotiating with their spouse over unmet family planning needs.

In the South-Kivu region, the ongoing unmet need for contraception, despite the availability of modern methods, suggests there is still much to learn regarding the intersectional, socially charged motivations and barriers to family planning use. By exploring women's opinions about family planning and its use, this study contributes to the growing body of literature framing reproduction, fertility and family planning use as socially embedded issues (Bongaarts and Casterline 2013; Johnson-Hanks 2007; van der Sijpt 2014). These findings can inform the development of future programmes that address the context-specific realities of women's use of family planning.

Methods

Study setting

This study was embedded in an evaluation of the *Mawe Tatu* [i.e. Three Pebbles] programme implemented in North and South Kivu, DRC. This programme aimed to

improve household economic status through Village Savings and Loan Associations (VSLA), while sensitising women and men to different topics including family planning. Due to security and logistical issues, qualitative data collection was limited to two health zones in Bukavu urban centre in South-Kivu – Bagira and Kadutu. Religious groups mainly run the health facilities in these health zones, with most patients and providers identifying as Christians.

Study design, participants and data collection

This qualitative study involved two waves of data collection by means of focus group discussions (FGDs) and in-depth interviews (IDIs). Data were first collected in 2017-2018 with follow-up in 2019-2020. The decision to follow up participants in this was influenced by our supposition that, with time, it was expected to find more women using family planning as information about access and the methods available became more widely spread. In addition, we were concerned that due to the sensitivity of the topic, participants might not openly express their views about family planning until the second round of interviews. Themes such as attitudes towards, and the use of family planning including modern contraceptives, dialogue and negotiation about family planning within the couple, and perceptions/rumours about modern contraceptives were among the issues explored.

Study participants

FGDs. Women participating in the *Mawe Tatu* project were purposively recruited to the study. The initial choice of FGD and IDI participants was decided upon willingness to participate. A total of 52 women were recruited for an initial interview in 2017-2018 (of whom 52 participated in seven FGDs and seven participated in IDIs). Forty-nine of the same women participated in follow up FGDs in 2019-2020, and five in IDIs (see Table 1).

Later on as part of a follow-up, two FGDs (Group 2 and Group 5 in Table 1) were undertaken on the same day, divided into two sub-groups of four young persons (20-30 years) and four not young persons (above 40 years). In the sub-groups, young women were more willing to share the challenges they had encountered regarding the use of natural family planning methods.

IDIs

To contextualise FGD participants' family planning beliefs and patterns use, we interviewed a number of women as key informants based on their knowledge of the context, the comprehensiveness of their responses, and the fact that they were willing to share

Table 1. Participants in FGDs and IDIs.

	FGDs ($n=7$)							
	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	IDIs
Round 1 (2017-2018)	6	8	8	7	8	8	7	7
Follow-up* (2019-2020)	4/6	8/8	8/8	7/7	8/8	8/8	6/7	5/7

*Participants we were able to follow up from Round 1.

their experiences (Fetterman 2020). Key informants were chosen from among the FGD participants and were those noted to have given particularly detailed and comprehensive responses to the questions asked in the FGDs in which they participated.

Lost to follow-up

Over the two year period, three women from the initial FGDs were lost to follow-up; one moved to another region, and the two others could not be contacted again. We had planned to interview all IDI participants at least twice but one was not available for a second interview and one explained that she did not have any further information to provide since nothing had changed from the first interview.

Data collection

Data collection took place in a participant's household or in church buildings chosen by the participants. IDIs and FGDs were voice-recorded, translated from the local language into French/English, and transcribed for analysis. We stopped data collection when saturation had been reached.

Data analysis

An inductive approach to content analysis was used, without preconceived ideas guiding coding (Hsieh and Shannon 2005). The triangulation of data from the FGDs and IDIs helped us gain a more comprehensive understanding of the issues being explored (Lambert and Loiselle 2008). Combining the data sources also enhanced the trustworthiness of findings and enabled the identification of individual and contextual influences. A native speaker transcribed the data from Swahili into French. Where necessary, translations were discussed with the key informants to clarify the meaning. The translation of some key terms was further discussed between the two first authors and the team lead (WB, MD and SM). Members of the research team read the first set of interviews to identify emergent themes, some of which were used as initial codes. A careful re-reading of the interview transcripts, comparing first and second interviews, and forming new codes, identified subsequent more hidden themes. An initial codebook was developed, discussed within the team, and refined and edited as analysis progressed. Informed by emerging hypotheses, the results were integrated into the broader contextual analysis that is offered here.

Ethical considerations

The study was approved by the Ethik Kommission Nord-und Zentralschweiz in Switzerland and by the Ethics Committee of the Catholic University of Bukavu in the DRC. Informed verbal and written consent was obtained from each participant prior to data collection. Anonymity and confidentiality were guaranteed to the best of our ability, as we could not control whether FGD members shared information outside of the group. Any participant requesting assistance with family planning was referred to the nearest appropriate health care facility.

Findings

Participant characteristics

FGD participants ($n = 52$) and in-depth interviewees ($n = 7$) were all married and ranged in age between 22 to 50 years. More than half of the participants were *ménagères* (i.e. 'stay-at-home mothers'), fifteen were involved in small businesses (selling fish, beans, etc.), two were state employees, and one was a teacher.

Principal findings

Four main themes were developed from our analysis of participants' perceptions of family planning: (1) awareness, precariousness and value of children, (2) religious beliefs, (3) perceived side effects of family planning and (4) societal norms influencing family planning choices. Participants were able to identify both traditional and modern family planning methods and were aware of places in their community where they could access family planning services.

While participants were able to identify the justifications for using family planning present in government and NGO messaging, only three out of 52 women were using family planning at the time of data collection (second wave) and were thinking of continuing. Overall, findings illustrate how women sought to navigate tensions between insecurity, poverty, and family/societal pressures when making family planning-related decisions.

Theme 1: awareness, precariousness, and the value of children

Awareness and choice of family planning methods

Family planning was understood in the local community as a way to limit or space births. Participants reported they could access family planning services at local health facilities.

> There at the health centre of the Christian community you can get information and any methods you want… (Female, 32 years, 5 children, FGD Round 1)

Many participants preferred natural methods, however, such as *buchanga* or the calendar method.

> Counting the days is what I am doing… we had what they call the "rosary". They give it to us at health centres. We [My husband and I] used to use it and I was spacing births for two years… (Female, 28 years old, 4 children, FGD Round 1)

Participants also identified contraceptive pills, condoms, implants and Depo injections as familiar family planning methods. However, even though mass media campaigns encouraged people to use family planning, most participants were reluctant to do so. Participants were, however, more open to condom use than long-acting hormonal contraception.

> We [my husband and I] are not planning to use [family planning]… but if I had to choose maybe condoms, not the other [methods] … (Female, 26 years, 3 children, FGD Round 1)

Family planning and precarious future

Life in the DRC is precarious. Meeting daily needs is increasingly challenging, especially for large families. This precariousness pushed two participants to start using family planning.

> Because life has become difficult today… birth planning is necessary to have the means to feed these children and to make them grow… (Female, 30 years, 4 children, FGD Round 1)

Being a young woman and providing for the family

The main justification women, both former and actual users of contraception, gave for using hormonal contraceptives was to keep working while their male partner was unemployed. In an increasingly competitive society, in which more and more women are contributing significantly to household income, a teacher felt that spacing births was the only way to secure the future.

> I was the only one working at that time, so we did not have any other choice than to not give birth at the moment, we decided to use [contraceptive] injections … (Female, 32 years, 4 children, IDI Round 1)

Another woman had had four children and said her business and family income depended on her not giving birth again.

> We are still young. I am a saleswoman… my husband has no steady job. So, if I start giving birth every day, what are we going to become? My business will stop. And my family will starve… I took the Depo [injection]… I haven't been used to it for long… but I'm going to keep doing what I'm doing [selling fish]… (Female, 28 years, 4 children, FGD Round 1)

For another woman, the fact that her husband worked in another province explained why they were using family planning.

> …my husband is working far [away]… when he is back, if you're in a bad [fertile] period [in your menstrual cycle], you're not going to tell him no (when he wants to have sex), 'listen as we plan to wait a bit (because you are using natural methods)', no… So, I had to take the 3-month injection. Now I'm comfortable even if he comes [back], there is no problem… (Female, 26 years, 2 children, FGD Follow-up)

However, some participants suggested that their precarious reality would not automatically lead them to use family planning. An uncertain future pushed them to have as *many* children as possible, but children were still valued because they did not know how many would survive into adulthood.

> Let us suppose that you have one or two children, you know the realities we are living with, all those kids' diseases. And let's say you have bad luck [and] both of them die when they are still young…who would you run to? … (Female, 35 years, 5 children, FGD Round 1)

Children: wealth or burden?

For many women and men, planning to have a set number of children was not a priority. Very few participants said they discussed their desired number of children with their partner.

> We discussed about the number of children [before], like when we got married he wanted 4 children, me I wanted more… but now we don't talk about it, we just receive what God is giving us… (Female, 35 years, 5 children, FGD Round 1).

Participants described the socio-cultural value associated with high parity. Women reported that although times have changed and life was more difficult, children were not a burden. In fact, having a number of children is a joy, as well as a practical 'blessing'.

> You know having children is such pure joy, you know how many [people] want children?… I cannot lie; all of us are standing here because of our children… (Female, 28 years, 4 children, FGD Round 1)

A different participant described the deeply important cultural meanings associated with having children, especially for women:

> A married woman without children is not respected. But if they call you 'Mama Fulani', meaning the mother of someone, everybody will respect you… (Female, 33 years, 3 children, IDI Round 1)

Another women said, "if God brings a child, He will also bring his plate….' (Female, 33 years, 3 children, FGD Follow-up), meaning if God gives you a child, He will give you what is needed to feed him.

Theme 2: not a choice, but god's will: religious beliefs and family planning decision making

Religious beliefs were among factors influencing family planning beliefs and practices for all participants. They identified themselves as Christian, either Catholic or Protestant. God or religion were often mentioned in relation to family planning. Participants reported meeting weekly in '*shirika*' (a small social unit of a church where Christians meet to share gospels and other church news) for sensitisation on different topics, including family planning. Sensitisation to family planning occurred two or three times a year in the *shirika*. Usually, a health care provider was invited to speak in the presence of the priest/pastor and general information on family planning was provided in the context of the Catholic or Protestant faith.

Some women framed their beliefs regarding birth or the spacing birth in terms of divine intervention. If Christians ask God for a favour, for example, to have a child or a birth spacing of two years, and they are good Christians, their prayers would be answered:

> Yes, God has given [us] intelligence, but what you ask God for you shall have. For those for whom it does not work [their prayers are not answered], there is a problem, something must be wrong somewhere, but when I ask God for something, He gives it to me… (Female, 51 years, 7 children, FGD Round 1)

Other participants believed that fertility was predestined, that God was in complete control, as evidenced by women's varying experiences and timing of fertility. Therefore, there is no need to manipulate or control fertility:

> … there is nothing to do, you cannot [control fertility] There are women who want to give birth but they can't, others don't want [to] but they give birth, some women give birth after two years, others about four years without using anything… God gives to everyone differently… (Female, 44 years, 5 children, FGD Follow-up)

One woman suggested that using contraceptives could interfere with one's destiny and could risk 'losing' one's chance given by God:

> You may decide to use a contraceptive, but what if that was the only time that God has planned for you to have a child. You will lose your chance then begin to ask God without knowing that He has already given you [your chance], but you refused to take what he gave you… (Female, 50 years, 5 children, FGD Follow-up)

Other participants expressed powerlessness to control births because family planning does not work for everyone. Participants cited people who has used a contraceptive method, but it did not work while others were able to space births without using any family planning. One woman explained:

> Every woman has her children in her belly; there is nothing one can do. If it was written two children for you that is it. It all depends on how you [the woman] were created. You cannot change that… (Female, 40 years, 4 children, FGD Round 1)

Finally, for many participants, both non-users and former users, modern contraceptives were seen as going against the will of God by killing life.

One of the potential 'punishments' God could inflict for using family planning included side effects, sterility or enhanced vulnerability to diseases such as malaria:

> There is a woman who had put this [implant] in for five years. Her husband said she must take it out so she can give birth now.' 'It has been five years now, she is trying to conceive without success… (Female, 50 years, 6 children, FGD Follow-up)

Theme 3: side effects: god's punishment, or simply misfortune?

Unlike hormonal contraceptive methods, participants reported natural methods did not have side effects if the couple managed to follow the instructions provided by the health provider. In contrast, participants reported side effects from hormonal contraceptives based on their personal, or relative or friends' experiences. Some participants reported feeling guilty after experiencing side effects:

> I told him [her husband] that what we had agreed on [wife taking hormonal contraceptive, injection] wasn't right for my health. I told him that God did not want that. He asked me to get some medicine to help me, but there was none at the health centre. I went from one [health] centre to another without getting help … (Female 40 years, 4 children, IDI Follow-up)

Women non-users also described the possibility of migrating contraceptive implants. Should pregnancy occur, they said, the misplaced implant could endanger the woman and the child.

> We did not know that this metal [implant] had left its original location and implanted itself in the uterus. When she [a woman she knows] pushed the baby, a metal appeared. The health worker told us that this metal was placed in the arm, but it is already in the

> womb… Wasn't she pregnant while she was doing family planning, and that pregnancy almost killed her?… (Female, 50 years, 6 children, FGD Follow-up)

Women described irregular bleeding as the main side effect of hormonal contraceptive methods. One woman reported what had happened to a relative:

> There is one woman who had taken this Depo … she was bleeding like a [slaughtered] cow. Sometimes she had started putting on plastic rubber pads because of this Depo. The nurse could not help. They [the hormonal contraceptives] are harmful to a woman's body…. (Female, 28 years, 4 children, FGD Follow-up)

A participant's husband who was unemployed suggested she took modern contraception in order to keep her job. However, irregular bleeding quickly made them discontinue the use.

> [My husband] was the first to raise the idea to look for a contraceptive so as not to continue giving birth while life is difficult and without a job… I took Depo for three months. Then I was bleeding continuously, from the beginning of the month to the end, I did not know where to go to seek for help… I then swore to [my husband] not to do that anymore, maybe if he could go [to the health centre] because even men go there, either for injection or for tablets… (Female, 40 years, 4 children, IDI Follow-up)

Other participants reported weight loss or gain, as side effects. A woman non-user described a friend who had lost so much weight after having an IUD inserted that people thought she had AIDS.

> She lost weight, and everybody was thinking that she had AIDS, but it was because of the metal they put in her… (Female, 28 years, 4 children, FGD Round 1)

Participants also shared a strong belief that contraceptives triggered uterine cancers in women through unknown mechanisms.

Theme 4: societal norms

Participants' accounts revealed that individual personal beliefs were not always the sole factors influencing the decision to use contraception. Health care providers, family/community perceptions, power dynamics and gender norms also seemed to play a role in family planning decision-making.

Health care providers: if they don't, why should I?

Non-user participants reported that some health care providers recommended that people use family planning but did not do so themselves:

> His [nurse's] wife is giving birth every day [every year]; why should I practise these methods? (Female, 28 years, 3 children, FGD Round 1)

Another woman refused to use modern contraceptives despite her husband being a nurse.

> … he is my husband and a nurse… I do not even ask myself any question about that… He is the one who decides. And he doesn't want [to use any modern contraceptive] so we don't use [it]… (Female, 22 years, 3 children, IDI Follow-up)

Family planning, a 'couple's business'?

The majority of participants reported that the decision to use contraception, whether modern or a natural method, was a "couple's business", and that both the man and woman should participate in decision-making.

> Family planning concerns equally men and women… Because you cannot do family planning if your husband doesn't agree… You must talk to each other… (Female, 30 years, 4 children, FGD Round 1)

There was a generational difference in perceptions of the use of family planning. Young women and men were more likely to be positive about the use of contraceptives than older women or men. In one FGD, a younger participant reacted as follows to older participants' advice to stick to natural methods if they needed to use family planning:

> I have understood what our mums have just said now. I respect their advice. However, things are difficult; the counting method does not work. They [elders that she called mums] are here; tell me who here if her husband asks [for sex] during the night they will easily say no you know we are planning, I am in my fertile period…… but having this implant helped… (Female, 29 years, 3 children, FGD Round 1)

Not all participants found discussing contraception within the couple to be taboo; however, going to seek information about family planning at a health facility was perceived as a woman's business. Men reported feeling uncomfortable in antenatal/postnatal care that were perceived as the *'women's* sessions. While a man might be encouraged to accompany his wife to such a sessions, he could often find himself being the only man in attendance. It was reported that it could also be difficult for the couple to go together to family planning counselling because someone needed to stay at home to look after daily household tasks:

> Some men may stay home taking care of the children… The consultation can last all day… Not that the visit itself is long but the time to reach the health facility, the time for the nurse to be available if they are notwithstanding of emergencies and the time to come back home… (Female, 32 years, 5 children, FGD Round 1)

In addition, some young women preferred to go to family planning sessions without their partners because they found it was an opportunity to meet with peers in a social setting.

> That is our time to meet with friends and discuss women stuff between us; he doesn't have to be there… (Female, 32 years, 2 children, FGD Follow-up)

In addition, some men only gave money to their wives for health facility visits and related fees. In these cases, women found an opportunity to leave the house alone and asked their husbands for as much money as possible:

> … [attending family planning sessions is] also my way of earning something (laughs), when I go I can even ask for ten dollars or even 20 because he has to pay for the transport and the fees at the hospital and he's going to give (laughs)… It's going to be my pocket money… so if one day he comes it's all over, that's why it's better that they don't come… (Female, 33 years, 3 children, FGD Follow-up)

Women explained that they were also afraid of how men might react should their wives require a medical examination, especially if the provider was male:

> But men are also complicated… sometimes the nurse or the doctor must examine you, men are very jealous, especially if it is a man [health provider] who is there, he will get angry, maybe not even talking to you for a while… that is why it is better that (I) go alone (to those consultations). Then I give him the report… (Female, 30 years, 4 children, FGD Follow-up)

In the case of disagreement over the use of family planning, we found that the woman was supposed to give in to her husband's wishes in order to avoid being treated as unfaithful. However, exceptions existed. A woman might decide to take contraceptive pills without telling her husband because she wanted a break from childbearing. Unfortunately, after experiencing side effects, she could be forced to explain the situation to her husband:

> I started to bleed every day regardless of my periods. [My husband] asked what was going on… I didn't explain, but when I saw that it lasted a month, two months… I said, eh I'm going to tell him so that someone [herself] doesn't die here without people knowing what was happening. (Female, 30 years, 4 children, IDI Follow-up)

In this particular case, her husband called her family, and she was blamed. Only her excellent negotiation skills prevented her from losing her marriage.

Gender power dynamics

Family planning use was also shaped by negotiations about sex within the couple. Traditionally in this context, a woman must be ready and willing to have sex when her husband asks. These normative power dynamics remain deeply anchored in society and affect couples' conversations around sex, including family planning use. Participant experiences navigating gendered divisions of power within the couple demonstrated the difficulties women faced in using contraceptives – natural or hormonal – and can explain the high rate of abandonment of contraceptives.

Women described the challenges they faced when they had to negotiate the timing of sex and how this could affect the efficacy of family planning, especially the use of contraceptive methods that needed husband's consent/participation such as natural methods and condoms. One participant and her husband went together for family planning counselling, and afterwards they chose to use the calendar method. However, it was not easy for the husband to comply during the days of abstinence:

> … he tells me: I want (to have sex)! I pretend not to have understood… because if you refuse, he gets very angry. I shut up and go to bed, until the next day. In the morning, he reminds me: I told you but you went quiet… Then he says: I knew that all these things would happen… You want to follow what those people say, then they will remain your husbands … (Female, 34 years, 5 children, IDI Round 1)

Fortunately, for the woman concerned, at their third family planning consultation at the health centre the husband decided to follow the advice of the nurse and agreed to abstain from sex during fertile periods. It is not easy for a woman to

negotiate or refuse sex with her husband and power dynamics within the couple affect the decision to practise family planning consistently.

Discussion

It is clear from our analysis that women's decision-making about contraception involves a negotiation between personal beliefs, social and cultural pressures, fear of modern hormonal contraceptive side effects and gender power relations with their partner. Uncertainty about the future and children's survival could explain why a 'rational' preference for small families does not necessarily fit in this or other similar settings (Moultrie 2012). Understanding what is tangibly and socially 'rational' within a particular context is key to better responding to women's family planning choices.

In moving forwards, counselling for side effects in regularly scheduled follow-up visits after the initial uptake of contraceptives could be helpful. Capacity building and training for health care staff on how to deliver comprehensive care from a psychological, somatic and cultural point of view, should be considered by the local and national health system and integrated into interventions aiming to increase access to family planning. Given their unique positions, as both clinical health system actors *and* community members, health care providers, for example, could be valuable resources when it comes to addressing barriers to family planning use by listening to couples' concerns and suggesting suitable ways of tacking the problems.

Working with religious leaders could also be step forward when it comes to reconciling community views with programmatic aims to increase women's reproductive autonomy, particularly in addressing side effects being erroneously perceived as God's punishment (Kaniki 2019; Ntambue et al. 2017).

Men's role as decision-makers provides women with little freedom to select a family planning methods of their choice. Contrary to other findings where direct communication about contraception with men was often challenging due to male resistance (Harrington et al. 2016), participants in this study were able to discuss contraception with their partners, a likely positive impact of family planning interventions in the region. However, the challenge will be to create friendly spaces for men beside "women's" sessions while preserving women's autonomy and allowing the couple to decide together on a family planning method that satisfies both partners. Male contraceptive methods, mainly hormonal and surgical, have fewer side effects; they should be presented with a similar emphasis as hormonal methods for women. Additionally, women who successfully navigate family planning, and the use of hormonal contraceptives in particular, could become advocates for family planning in the community by sharing their experiences to help others who are hesitant but in need of a means of family planning.

Overall, our analysis supports other calls for a more nuanced approach to addressing fears of family planning side effects, especially ones that take seriously the socio-cultural factors underlying these fears (Bledsoe 2002).

Limitations

Like all studies, this investigation has its limitations. Participants self-selected to join this research. As a result, some categories of women may not have been included

perhaps because they were too poor to travel to the host agency or because of a poor social network. In addition, while repeat interviews and focus group discussions have their strengths, interviewing the same persons on the same themes twice could introduce bias, with participants possibly trying to direct their responses in relation to what they thought the research team might have wanted to know. To reduce reactivity and respondent bias, the first author and research assistants used a variety of strategies including prolonged engagement in the field, theory and methodological triangulation, peer debriefing, and member checking. Finally, given somewhat adventitious approach to sampling adopted in the study, it is not possible to generalise the findings beyond the context in which they were elicited.

Conclusion

The use of contraception remains challenging in the community in which this study took place with many social and societal barriers restraining people from using family planning methods. Family planning use was influenced by the precariousness of life, women's and partners' beliefs, social pressures and gender power relations, as well as fear of side effects. Encouraged by their partners, young women who contributed significantly to household finances and/or were the sole household providers were more positive in their views about family planning than were those of older generations. Future programme efficacy may be strengthened through the involvement of husbands and religious leaders. Beyond this, health care staff require support to ensure an adequate contraceptive supply and good quality training to assist women and their partners in decision making regarding the use of family planning. This should include education about, and ways of mitigating, contraceptive side effects.

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