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Gendered power dynamics and women's negotiation of family planning in a high HIV prevalence setting: A qualitative study of couples in western Kenya

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Abstract

In sub-Saharan Africa, high burdens of HIV and unmet need for contraception often coexist. Research emphasises the need to engage men and couples in reproductive health, yet couples' negotiations around fertility and family planning in the context of HIV have been sparsely studied. This study examined the gendered power dynamics that frame women's and couples' negotiations of contraceptive use in western Kenya. We conducted 76 in-depth interviews with 38 couples, of whom 22 couples were concordant HIV-positive. Qualitative data were analysed using a grounded theory approach. Direct communication around contraception with men was often challenging due to perceived or expressed male resistance. A substantial minority of women avoided male reproductive decision-making authority through covert contraceptive use, with concern for severe consequences when contraceptive use was discovered. Many men assumed that family planning use signified female promiscuity and that infidelity motivated covert use. Men were more willing to use condoms to avoid HIV re-infection or at the recommendation of HIV care providers, which allowed some women leverage to insist on condom use. Our findings highlight the tension between male-dominated reproductive decision-making and women's agency and point to the need for gender transformative approaches seeking to challenge masculinities that negatively impact health.

Keywords

Gender; HIV/AIDS; Kenya; Masculinity; Reproductive health

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Introduction

Since the 1994 International Conference on Population and Development in Cairo, there has been a substantial increase in research seeking to understand the broader context of women's sexual and reproductive health. This has created much-needed linkages between the formerly 'siloed' concerns of family planning and other reproductive issues, such as sexually transmitted infections and HIV (Dudgeon and Inhorn 2004; Wilcher, Cates, and Gregson 2009). Other welcome shifts in the literature included a move away from the study of women alone to the inclusion of men (Dodoo 1998; Greene and Biddlecom 2000) and couples (Becker 1996; Irani, Speizer, and Fotso 2014). More recently, it has been increasingly recognised that global HIV efforts often fail to address the sexual and reproductive health needs of people living with HIV. Unmet need for contraception and risk of unintended pregnancy are known to be high in sub-Saharan Africa, and in Kenya specifically (Singh and Darroch 2012; KNBS 2015). Studies suggest an even higher burden of unmet need for contraception and contraceptive failure among HIV-positive women (Homsy et al. 2009; Bankole et al. 2014). These issues have sparked a movement towards integrated reproductive and HIV care (WHO, UNAIDS, and FHI 2009; Kenya MOPHS and Kenya MMS 2009).

Over the past three decades, gendered power dynamics have been theorised in a variety of ways (Riley 1997; Connell 1987), laying the groundwork for the application of these theories to sexual and reproductive health (Wingood and DiClemente 2000; Jewkes and Morrell 2010; Pettifor et al. 2012) and to understand the role of masculinities in sexual and reproductive health outcomes (Shai et al. 2012; Stern and Buikema 2013). Blanc (2001, 189), in her review of power in sexual relationships, emphasises the "comparative influence of each partner relative to the other" rather than on the absolute power of either member of a couple. Within studies of unmet contraceptive need, male resistance to family planning has often been a focal point in sub-Saharan Africa (Wolff, Blanc, and Ssekamatte-Ssebuliba 2000; Bawah et al. 1999). Thus, scholars have called for interventions to increase male involvement in family planning to reduce unmet need. However, there is also concern that such interventions could actually further constrain women's ability to use contraception on their own terms (Biddlecom and Fapohunda 1998; Mullany, Hindin, and Becker 2005). In addition, covert contraceptive use by women has long been recognised as an important consequence of relationship power imbalances (Blanc 2001), and "a practical strategy to subvert male authority" in some cases (Biddlecom and Fapohunda 1998, 369). A variety of validated scales have been developed with the goal of measuring gender-based power; though these scales have varying relevance to populations and contexts and cannot be compared (C-Change, FHI360, and USAID 2015). For example, Stephenson, Bartel, and Rubardt (2012) examined the associations between two validated scales of gendered power and contraceptive use among men and women in Kenya and Ethiopia. They found that higher scores on men's equitable attitudes scale correlated with higher reporting of contraceptive use. Utilising Demographic and Health Survey data from several African countries, Do and Kurimoto (2012) found that women's empowerment scores were associated with higher female and couple contraceptive method use.

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Additionally, multiple studies have examined the associations between HIV and relationship context/characteristics. Inequities in gender-based power influence multiple behaviours related to HIV risk, such as the negotiation of condom use and female-controlled methods for STI prevention, sexual behaviour within and outside of relationships, and sexual violence (Dunkle et al. 2004; Mantell et al. 2006; Parikh 2007; Muldoon et al. 2014). A case-control study in Uganda compared newly HIV positive young adults to HIV negative "controls," and found variations in relationship context; for example, the recent seroconverters reported poorer communication and more suspicion about infidelity (Higgins et al. 2014). While the balance of power within couples is known to affect women's reproductive health, few studies have qualitatively examined the ways in which couple power dynamics play out in family planning, particularly among individuals at high risk for unintended pregnancy—such as those living with HIV.

Research aiming to gain nuanced understandings of gendered power dynamics is crucial to interpreting and improving reproductive outcomes among HIV-affected couples. Because understanding gender relations involves the need to simultaneously understand masculinities and femininities, including both members of the couple in studies of family planning negotiation is valuable. In this paper, we examine women's negotiation of family planning use as a window into understanding gendered power dynamics among couples in a high HIV-prevalence context: Nyanza Province, Kenya.

Methods

Study setting

This qualitative study of couples was conducted between July–October 2010 in conjunction with Family AIDS Care & Education Services (FACES). FACES is a collaboration between the University of California, San Francisco (UCSF) and the Kenya Medical Research Institute (KEMRI). FACES partners with the government of Kenya to support HIV care and treatment at government health facilities, as well as community engagement activities, in Nyanza Province. Located in western Kenya bordering Lake Victoria, Nyanza Province has the highest HIV prevalence in Kenya (15.1%) at 16.1% among women and 13.9% among men (NASCOP 2014). Unmet need for contraception is also high: as of the 2014 Demographic Health Survey, 78.6% of reproductive-age women in Nyanza wanted to delay pregnancy at least 2 years or have no more children, while only 52.9% were using a modern contraceptive method (KNBS 2015).

In 2009, the UCSF/KEMRI collaboration initiated a cluster-randomised trial comparing integrated family planning and HIV services with the existing referral-based model. The present study emerged out of previous qualitative work during the cluster-randomised trial among HIV care providers and women and men living with HIV. Our previous studies raised many questions about relationship power dynamics and socio-cultural gender norms as factors in contraceptive access—factors that could not be addressed with interventions to improve health systems such as in the integration trial (Harrington et al. 2012; Newmann, Mishra et al. 2013). We sought to gain greater insight into couple decision-making and relationship power concerning fertility and family planning, in order to inform interventions targeting men and couples in the setting of high HIV prevalence. This study was approved

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by the institutional review boards (IRB) at both the University of California, San Francisco, and the Kenya Medical Research Institute.

Participants and sampling

Using convenience sampling, 20 heterosexual couples were recruited from FACES-supported government HIV care and treatment clinics in Rongo, Migori, and Nyatike districts, where at that time no contraceptive methods other than condoms were offered. At least one member of each couple was accessing HIV care, and both partners were aware of the other's HIV status. This strategy assured that at least half of couples would be seroconcordant HIV+ or serodiscordant. An additional 18 couples were recruited by FACES community engagement officers through purposive sampling in the same districts; HIV status was not an inclusion criterion. Female partners in both samples were between 18–45 years; in accordance with both IRBs, the decision was made to exclude minors due to concerns about vulnerability. All couples were in a partnership of at least one year so as to ensure that established power dynamics had time to develop in the relationships (Pulerwitz, Gortmaker, and DeJong 2000). This sampling strategy was devised with the goal of focusing on HIV-affected couples, while also integrating input from our FACES partners who wanted us to be able to draw some comparisons between couples living with HIV and HIV-negative and serodiscordant couples. Determination of HIV status was based solely on the report of the participants. The interview guide included the following domains: fertility intentions, perceptions of contraceptive methods, relationship decision-making and power, and unintended pregnancy. Given the high level of gender inequality in the region and limited support services, our research group and IRBs prioritised the protection of our participants from possible emotional distress and/or retaliation within the relationship. Thus, we avoided topics such as infidelity, asking men about covert contraception among women, and the introduction of HIV into the couple—though participants commonly broached these issues.

Experienced, trilingual (English, Dholuo, Kiswahili) interviewers conducted semi-structured, in-depth interviews with respondents; each interviewer was trained in the qualitative methods used in the study, as well as ethical research practices. Interviewers were matched to the sex of the respondent, and female and male members of the couple were interviewed individually and at the same time as their partners in order to maximise privacy. The interviews took place either in a private area of the clinic, or at the respondent's home, over 60–90 minutes. All interviews were conducted in Dholuo (the language of the Luo people), digitally audio-recorded, transcribed, and translated into English. Written informed consent was obtained from each participant prior to the interview. At the conclusion of the interview, each participant received the equivalent of US$3.

Data analysis

Transcripts were analysed with an inductive, grounded theory approach (Strauss and Corbin 1998; Charmaz 2006). Two members of the research team constructed an initial codebook in two steps. First, investigators read all transcripts and field notes, and randomly chose six interviews (three couples) for independent line-by-line open coding (Strauss and Corbin 1998). Secondly, the research team, including the principal investigator, met to reach consensus on initial codes. Once the code-book had been finalised, all transcripts were

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independently coded in Atlas.ti 5.6 (Scientific Software Development, Berlin, Germany) by two investigators, who met after coding an additional six interviews to compare codes and qualitatively maximise inter-rater reliability. The transcripts for each couple were read and coded as a dyad to allow for similarities and discrepancies between the female and male partners to surface. However, women's family planning negotiation strategies in the context of the couple were the focus of this analysis, and thus we analysed thematic domains primarily across gender rather than by dyad. Atlas.ti was used to group codes and categories during the axial coding process and subsequent memo-writing. During this process, investigators analysed the data in conjunction with defined and emerging concepts in an iterative fashion. The broader research team, representing perspectives from medicine, public health, and medical sociology then critically evaluated the memos to further refine the categories and concepts that emerged from the data. The following analysis draws on a total of 76 interviews among 38 couples.

Results

Among the 38 couples included in our analysis, 22 couples were sero-concordant HIV+, 10 couples were sero-concordant HIV−, 2 couples were sero-discordant (male partners HIV+), and 4 couples had one partner with unknown HIV status. The median age of female respondents was 30 years, while the median age of men was 38. Fourteen (37%) of 38 couples were in polygamous relationships. See Table 1 for sample characteristics. In the results that follow, we examine the strategies women used in family planning negotiation with men, and the power dynamics reflected in these negotiations. Each quoted respondent has been assigned a pseudonym.

Strategies for family planning negotiation

While perspectives on gender roles in reproductive decision-making were notably divergent within and across the women and men in our sample, final (overt) decision-making authority concerning family planning was generally assigned to men. Despite men's and women's agreement that the decision to use contraception was ultimately male-dominated, women were expected to initiate interest in and take responsibility for family planning as the ones who "bear the burden" of pregnancy, childbirth, and the care of young children. When asked about how couples make decisions about family planning in his community, one male respondent describes both aspects of this duality:

> It's the women who will see that, 'Eh! These children, my health is not good, let me take care of the ones I have given birth to [already]. Now let me talk to my husband so that we have one voice.' Because there is no day the man will tell you that, 'the one child that I have, I want us to practice family planning from there', he will not accept unless it's the woman…who will go to him with sweet languages, and get to convince him.
>
> …It's the man who will go, go and decide that 'this is what we are going to do.' The woman can propose, can come up with an idea that 'I want us to…start family planning,' But, in marriage it's the man who says the last and says 'mm! For sure let's do as you say' or says 'wait for a while, until either one or two [children] first,

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> that's when we'll do that.' So it's the man who…makes [the] final decision. (Okeyo, 35 year-old man, HIV+)

Women who wanted to use contraception responded to this mismatch between their family planning responsibilities and their ostensible lack of decision-making power in varying ways. Several women described simply waiting for their male partners to bring up family planning, and then agreeing with them. Many women, consistent with gender norms that define male household decision-making, asked their male partners for permission to use contraception and waited for the partners' answers:

> I cannot decide on my own…I suggest [family planning] and when I realize that what I have said is hard for him then I go back and consult further, so until I will feel that he is loosening up and coming down that is when I will remind him, 'the father of so and so what do we do about that issue I raised?' and he will say that 'I heard what you said and I will give you an answer,' so I wait for his answer. (Adhiambo, 40 year-old woman, HIV+)

A few women employed a more active strategy for negotiating family planning use—"sweet talk":

> If maybe you have six children and he still wants to add more children so that they can be ten and you are feeling the burden in the house, you will just agree with him and explain to him about that and you tell him that you should have some spacing. You just sweet talk him gently; you tell him that if the children are born without any spacing between them you may not be able to take care of them…You just sweet talk him softly and he will come around. (Apiyo, 30 year-old woman, HIV−)

However, asking permission and "sweet talk" required direct communication with male partners about contraception. In many cases, women portrayed the power dynamics in their relationships as excluding such direct communication. In response to both perceived and expressed male resistance to family planning, many women did not feel that they could fulfil the gender role of initiating communication or interest in contraception for fear of consequences. As one mother of 6 recalled,

> I feared telling him, because according to him…children are gifts from God and no one should think of preventing the God-given gift, but instead of giving birth all the time, you might think that it is better to go…[to the clinic for family planning]. When you go back to him, he is very harsh…But the good thing with the injection is that you can secretly go back after three months. (Sarah, 40 year-old woman, HIV−)

A substantial minority of women in our sample negotiated family planning through covert contraceptive use, thereby avoiding the need to directly communicate with their partners about family planning.

Covert contraceptive use

Over one quarter (11, or 29%) of women in the sample disclosed that they had intentionally concealed, or were currently concealing, contraceptive use from partners. While the remaining female respondents either denied practicing covert use or did not directly answer

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the question, almost all women spoke of their opinions on this topic, or shared anecdotes of other women's experiences with covert use. The motivations for "hiding," as many women called it, focused on male partners' resistance to family planning, or women's assumptions about male resistance in the absence of communication.

When discussing motivations for covert use, women emphasised men's cultural expectations of childbearing and the difficulties in challenging these views. Several women brought up discrepant fertility intentions between themselves and male partners as one barrier to open communication, with men generally desiring more children than women. One young woman described her experience of attempting to access contraception without her husband's knowledge, though she was ultimately unsuccessful:

> A woman can decide that three children are enough for her while her husband will say that five children are enough for him. So this is what will cause [secret use]. I mean…there is pressure that comes from the husband as the head of the family. So this pressure is what will make one to hide and come for the [injection]. (Achieng, 25 year-old woman, HIV+)

This respondent went on to explain:

> But I never told him, I just felt that if he knew that I wanted to go for family planning and I have [only] one child, imagine what people think, he has just paid dowry for his wife and she has given birth to one child and then she has gone for family planning, what reason can you give?

The practice of paying dowry at the time of marriage was mentioned several times by male and female respondents, whose descriptions of the practice centre around the expectation of childbearing. Expectations of childbearing in marriage were seen as inherently limiting to family planning use, and contributed to difficulty communicating about and negotiating family planning. A participant who was currently concealing her contraceptive use framed her difficulty in negotiating contraceptive use through an understanding of marriage expectations more generally:

> [Men] cannot take their wives for family planning [because] they paid dowry so they could get children, so women should pay back the debt that the men had paid to their homes. (Anne, 40 year-old woman, HIV+)

One of the most prominent themes concerning male resistance to family planning was the widespread assumption that contraceptive use led to or signified female "promiscuity." Women's desire to avoid male suspicion regarding sexual infidelity was commonly reiterated as a reason to keep contraceptive use secret:

> [Men] feel that if the woman can go for family planning they feel that they shall have allowed them to be promiscuous…that you have been given a chance to be promiscuous; because he knows that you will have affairs and not conceive. (Charlotte, 25 year-old woman, HIV−)

Women's fear of being labelled as "promiscuous" or even as a prostitute[1] contributed to a lack of communication within some couples about family planning. Even among women

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who took the risk of voicing interest in contraceptive use with their partners, such concerns over "promiscuity"-related stigma, made it difficult to engage in further discussions:

> I am the one who first informed him about the idea [of family planning], and he told me… that 'a woman should not go for family planning because she will come back and embark on prostitution'…This is what made me go for family planning without his knowledge. (Akinyi, woman who did not know her age, HIV+)

Men also recognised that if women initiated discussions about family planning, men might perceive this as evidence of female extramarital sex; they acknowledged this dynamic as a major barrier to open communication. At the same time, nearly all men advocated for themselves to be part of the decision-making process, and many implied that women would find them willing to participate if they were allowed:

> …You know the reason why women in many [cases] don't ask their husbands if they can go for family planning is that the woman thinks that anytime that she will ask the husband to go for family planning then it will mean that she has been a prostitute, so she wants to be wise so that she cannot conceive where? Outside the marriage. But you find that if they are allowed, many men would want to plan their families because they are the ones who go to work and look for money and they know how hard it is to get that little money. (Joseph, 45 year-old man, HIV+)

While concealed contraceptive use represents, on some level, autonomous decision-making, participants did not celebrate covert use as an empowered choice. Rather, covert use was overwhelmingly portrayed as a secretive act and as a source of guilt and fear. Several women cited fears of serious consequences of covert use when men discovered it, including loss of trust in the relationship, violence, stopping contraception use, being sent back to one's ancestral home, and men seeking additional sexual partners or wives. For example:

> What he can do [if he discovers], he can even chase me away…The way I see him he can just chase me away for good, because he does not want it so much so that if he discovers we can have a disagreement forever. (Eliza, 20 year-old woman, HIV −)

Covert use and contraceptive choice

Covert use constrained some women's choice of contraceptive method, primarily related to ease of concealment. For example, the injection was the most commonly concealed method among the 11 women who reported covert use, though the contraceptive implant and oral contraceptive pills were also cited as practical for concealment depending on the circumstances.

> During those days when people were getting educated, my heart really wanted but my husband did not want, so I just went for pills but because [they were] something visible …yet when I go to the hospital after every three months nobody can find out, I decided to use the injection, and it is even easier to remember when to go back for the next injection…. (Sarah, 40 year-old woman, HIV−)

[1]The terms 'promiscuous' and 'promiscuity'/'prostitution' were used interchangeably in the translation from Dholuo.

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A few women also experienced difficult-to-conceal changes in bleeding patterns with their chosen method, in some cases leading to inadvertent disclosure: "What happened was that blood was coming out of me all the time…Without breaks I looked like someone who was [having monthly periods] all the time…He realized." (Akoth, 29 year-old woman, HIV−)

Men and covert use

Men were not specifically queried about women's covert contraceptive use, as there was concern on the part of study investigators that such questions could lead to male suspicion and possible confrontation or violence with female partners. Nonetheless, this domain surfaced spontaneously in interviews with over one-third of male respondents. Men's perspectives on "secret" contraceptive use focused on relationship conflicts that might result when men discover use. Several men spoke of men's betrayal or humiliation upon discovering covert use. They corroborated women's fears of the consequences of covert use and discussed the topics of gender-based violence, relationship dissolution, and male partners marrying another wife.

> Then you get surprised to see the woman plant something on her arm [referring to contraceptive implant]…someone tells you that this woman will not conceive for about three years. Do you know you are going to chase her away, yes, because this woman went…for family planning…and [her husband] doesn't know. Maybe this woman has gone for TL [tubal ligation], and that wife of yours will not give birth. That man, it might force him to add another wife. (Samuel, 36 year-old man, HIV+)

Men generally distrusted women's intentions when they used contraception covertly:

> Most women today would want to practice family planning, but you find that men are the ones who dictate to them…Yes, because maybe the woman has gone for family planning secretly you think she has an agenda, that maybe she is promiscuous, or what would she be planning? What has she thought of that she doesn't want to give birth…? (Okello, 38 year-old man, HIV+)

Only one man (Owiti, 50 year-old man, HIV−) admitted to having been "deceived" himself, though several female respondents described experiences of covert use detected by partners. This respondent, however, supported his partner's contraceptive use after finding her clinic card. His female partner (Sarah, 40 year-old woman, HIV−) had presumed his resistance to contraception, and felt "engulfed by fear because [using secretly] was like stealing something." She described relief after telling him her rationale for using contraception, and found that he reacted kindly. At the couple level, this dyad exemplifies gendered power imbalances that yield communication gaps and silences, and the dilemmas many women face regarding family planning negotiation overall and disclosure of contraception use. In parallel, a previously quoted female participant (Akoth, 29 year-old woman, HIV−) described a less supportive reaction when her husband discovered her contraceptive use, though it did not result in the severe consequences she had feared. When he found out, "he felt bad" and she "left" family planning—then giving birth to her fourth and fifth children. While most men acknowledged male-dominated decision-making around contraceptive use, some also expressed a willingness to negotiate with women around family size and family planning:

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> The ideas of the man are used [in deciding whether to use contraception]…but… my wife can tell me that this [family planning method] is good and I will see that it is good and we agree. Because everyone has ideas but you know men are tough, there are some who refuse that women cannot talk to them yet the woman has very good ideas. (Joshua, 55 year-old man, HIV+)

We did not find departures from the above findings among polygamous couples.

HIV and contraceptive negotiation

Concerns and realities around HIV pervaded both HIV+ men and women's fertility intentions (Withers et al. 2013), but HIV surfaced very little in discussions of relationship dynamics—with the exception of dynamics around condom use.

Many of the couples living with HIV described that they were positively influenced by clinic providers (after first learning of their status) concerning the decision to use condoms consistently; of 24 couples in which at least one partner was HIV+, over 50% (13) were using condoms only for contraception, and another 3 couples were using condoms in addition to other methods. Both women and men emphasised that the condom is being advertised such that "both the man and the woman get to hear about it…yes, it cannot be one person's idea…" (Omondi, 50 year-old man, HIV+)

Men who may not have been willing to use condoms for contraception or STI prevention, or at female partners' requests, were willing to use condoms to avoid HIV re-infection, which occurs when an individual who already has HIV contracts an additional HIV strain through unprotected sex:

> It was my decision as a man because if a woman comes to you that you use condoms and it is not your decision, you will not accept. Those are the things that bring tension between people who live together but if it is a man who has decided then the wife will accept. So I felt that I should use condoms and I know what it means. I told her that if we don't use condoms then we will re-infect each other and we will die. (Patrick, 57 year-old man, HIV+)

Another male respondent put it this way:

> The way we have sex may have changed when we came from the hospital…we were told how we can help ourselves, that we can use the condom, so whenever we have sex we use the condom…before we knew [about our HIV status] we used to have sex without protection. (Joshua, 55 year-old man, HIV+)

Among women in seroconcordant HIV+ or HIV discordant relationships, 18 of 24 wanted to stop childbearing altogether, and only one desired conception soon. From several women's perspectives, concerns about HIV re-infection and the context of both partners receiving counselling about condom use allowed women leverage to insist on condom use. When asked about whether she and her partner have differences in opinion about contraception, one woman explained: "We can differ because he used to say that he is not used to using the condom since we used to do it without, and I can tell him that 'no just use the condom because of our condition.'" (Harriet, 30 year-old woman, HIV+) Similarly, the prospect of

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using the condom alone—a contraceptive method that has buy-in from both partners—was seen as a way to bypass the necessity for covert use:

> We chose the condom because of [this] issue; when I was using the injection, I kept it as a secret from my husband…I used to come and they inject me without his knowledge—but we both know about this one [the condom]. (Atieno, 30 year-old woman, HIV+)

Discussion

The present study analyses the dynamics around family planning among couples from the perspective of both partners, and adds to the nascent qualitative literature on couple relationship dynamics around family planning in the context of high HIV prevalence. This paper's contribution to the literature is relevant as programmatic efforts in sub-Saharan Africa begin to incorporate a focus on changing masculinities, challenge gender inequity, and continue to focus on meeting the reproductive needs of people living with HIV. Our findings characterise the tensions between women's agency and the constraints of gendered power relations within this sample of Kenyan couples. Our results support more qualitative similarities than differences between couples who were and were not living with HIV. This overarching comparability is affirmed by other recent studies comparing unmet need for contraception and relationship dynamics among samples of HIV positive and HIV negative persons (Bankole et al. 2014; Higgins et al. 2014).

Covert contraceptive use by women figured prominently in our results. Little outside of the study of female-controlled methods of STI prevention has been published about covert use in the last fifteen years, though this phenomenon continues to provide a window into many women's experience of gendered power in the reproductive health arena (Mantell et al. 2006). Small studies from Zambia, Uganda, and Kenya in the 1990s estimated the prevalence of concealed contraceptive use at 7–20% (Biddlecom and Fapohunda 1998; Blanc et al. 1996; Watkins, Rutenberg, and Wilkinson 1997; Castle et al. 1999). The first Kenya Demographic and Health Survey to report on covert use was published in 2010; 16.2% of married current contraceptive users in Nyanza Province admitted to concealed contraceptive use (KNBS and ICF Macro 2010). Using data from Zambia, Biddlecom and Fapohunda (1998, 366) described the motivations for covert use in terms of male pronatalism, male opposition to family planning, and "problematic spousal communication." Our findings enrich understandings of covert contraception use among a population of couples. While women in our study met some of their goals with covert contraception, almost all felt that it had negative impacts on the relationship, and was a source of shame and distrust.

Consistent with prior studies (Watkins, Rutenberg, and Wilkinson 1997), contraceptive use was perceived to indicate "promiscuous" female sexual behaviour in our study. Women's fear that male partners would assume they had extramarital partners was a major barrier to communication with men around family planning. Ironically, some women then turned to covert contraceptive use, which, if discovered, may lead to an even stronger assumption of culpability by men. The HIV literature holds an important parallel to these findings;

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women's requests to use male condoms have met with accusations of infidelity and/or prostitution in many settings, which presents a significant obstacle to women's ability to negotiate condom use (Heise and Elias 1995). Our study did not delve into unfaithfulness issues within couples and the introduction of HIV into the relationship, but this would be one direction for future research. In parallel, our research group has published elsewhere on the strong influence religious beliefs on fertility intentions and family planning decision-making within couples in this region (Withers et al., 2013), and our findings support religious opposition as a significant obstacle to contraceptive use.

Our findings suggest that HIV infection can alter the gendered and relational context in family planning negotiations given the 'dual protection' against both HIV transmission and pregnancy afforded by condoms. That is, men who wish to prevent HIV re-infection are more motivated to use condoms consistently than they might be to avoid conception alone. The reality of living with HIV appears to facilitate more open dialogue around condom use for affected couples, and some women use the fear of re-infection to their advantage. This finding is consistent with previous HIV-related research, which has found that an HIV positive diagnosis can loosen men's strict definitions of what it means to be a man to include more caring household and relationship behaviours (Peacock and Weston 2008). Thus, power dynamics are not fixed or unchangeable and are fluid, at play, and contested (Messner 1997; Peacock et al. 2009). Our group's previous work has hypothesised that integrating family planning with HIV care may allow for more open interactions between partners around contraceptive decision-making (Newmann, Grossman et al. 2013; Patel et al. 2014; Tao et al. 2015). This study suggests that when family planning becomes medicalised in the HIV care setting, health professionals' opinions and the goal of staying healthy may shift or supplant male-dominated patterns of resistance to family planning.

This study had several limitations. First, over half of participating couples were recruited at health facilities, and were successfully accessing HIV care and treatment. These respondents may not represent the perspectives of people living with HIV who have not sought treatment. We did not sample any couples whose relationship had ended, whether due to the HIV diagnosis or other reasons. Thirdly, our community sampling strategy was designed to complement and provide opportunity for comparison with the couples recruited from HIV clinics. HIV status was based solely on participant report. Given the risks of inadvertent disclosure of HIV status, stigma, and potential social or relational harm to participants, we could not use HIV status as an inclusion criterion in the community. Yet, purposive selection of serodiscordant couples may have added additional insights into HIV-related themes. Furthermore, given that many interview domains dealt with sensitive information, such as sex, contraception, and gender-based violence, some respondents in this milieu of sociocultural norms may have felt more comfortable discussing the experiences of other community members, rather than their own. This phenomenon may also be reflective of social desirability bias. Therefore, we recognise that both perceived and actual consequences of family planning negotiation strategies are discussed; community and personal experiences are both represented as such. In the current study, we found more similarities than differences among couples who were and were not living with HIV. It is possible that our sample size was too small to allow for theoretical saturation on HIV-related themes.

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However, our sample size was ample according to standard practices used in qualitative research methods (Morse 1994).

As governments, organisations, and scholars endeavour to decrease unmet need for contraception and prevent unintended pregnancy globally, finding new ways to understand and address gendered power differentials is essential. In sub-Saharan Africa, there has been much interest in efforts to further engage men in family planning. Interventions aimed at enhancing male involvement may be one of the ‘answers’, however, such interventions are feared to have the potential to tip the balance of gendered power towards men in unanticipated ways (Dworkin et al. 2011). In our study, women demonstrated active roles in negotiating relationship power around family planning. Yet, both men and women reported that male control over women’s fertility was pervasive. Thus, while women who desire to use contraception—including those who desire to conceal their contraceptive use from male partners—should be supported, systemic gender inequalities will limit the effectiveness of interventions aimed at women.

Multiple and complex factors, such as family planning-related myths, health concerns, and stigma; lack of trained personnel; inconsistent supply chains; and cost are implicated in reproducing unmet need for contraception globally. As unmet need translates into risk of unintended pregnancy, public health efforts continue to place a high priority on improving contraceptive access. Our findings from Kenya point to the need for gender transformative approaches and interventions that seek to challenge gender roles and masculinities that negatively impact health (Barker, Ricardo, and Nascimento 2007; Gupta 2001). Such interventions have been more common in HIV prevention and violence prevention (Barker et al. 2010; Jewkes et al. 2008; Dworkin, Treves-Kagan, and Lippman 2013), but gender-transformative programming is a promising area of future work within family planning. Gender transformative programming could direct male support for family planning into community ambassadors, or ‘champions’ who would influence not only dominant masculinities but also women’s perceptions of them. Furthermore, couple-level interventions that normalise communication around fertility intentions and family planning and stress gender equity messages are needed. Recent work suggests that health sector interventions, while they may only reach a small subset of men and couples, may be particularly effective (Kabagenyi et al. 2014; Matthews et al. 2013).

Interventions to decrease unmet need for contraception in settings with high levels of gender inequality must address the gendered power relations that may be particularly harmful to women’s and men’s health. The need to provide community-based family planning education in a way that is accessible and engaging to men, regardless of HIV status—while empowering to women—is critical. Gender transformative interventions should target common norms of masculinity that may impede open communication and male engagement in family planning. The current study, as well as our group’s previous work, support targeting norms such as perceptions that contraceptive use signifies female promiscuity, concerns about family planning use and health problems or sterility, and concerns regarding threatened male lineage (Withers et al. 2013). In the absence of such gender transformative work, interventions to improve communication between couples are unlikely to be successful, and may put women using contraception covertly at risk. Finally, the barriers to

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reproductive health faced by men and women living with HIV are in many ways similar to those facing HIV-negative individuals. Yet, there remains a disproportionately high unmet need for contraception among HIV positive individuals. As men's, women's, and couples' priorities align and intersect in new ways in the HIV care setting, this setting may provide a unique setting for future interventions with couples on family planning and gender.

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Table 1

Participant Characteristics

	Men			Women		
Characteristic	**N (%)**	**Mean (median)**	**Range**	**N (%)**	**Mean (median)**	**Range**
Age (years)	38	40.7 (41)	24–65	38	31.2 (30)	18–42
Age difference (man's age minus woman's age, years)		+11	−11–35			
Site of recruitment						
HIV Clinic	20 (52%)			20 (52%)		
Community	18 (48%)			18 (48%)		
Education						
Some/completed secondary	7/5 (31%)			4/4 (21%)		
Some/completed primary	15/8 (61%)			19/10 (76%)		
Unknown/none	3/0 (8%)			0/1 (3%)		
Polygamous marriage	14 (37%)					
Time with current partner (years)		12	1–25		11	1–25
Mean number of live children	38	5[a]	1–14	38	3.5[a]	1–7
Fertility desires						
Desire for child now	7 (18%)			4 (11%)		
Desire for child in the future	12 (32%)			12 (32%)		
Family complete	19 (50%)			21 (55%)		
Missing	0			1 (2%)		
HIV status						
HIV positive	24 (63%)			22 (58%)		
HIV negative	11 (29%)			14 (37%)		
Status unknown[b]	3 (8%)			2 (5%)		
Concordant HIV+ couples	22 (58%)					

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	Men			Women		
Characteristic	**N (%)**	**Mean (median)**	**Range**	**N (%)**	**Mean (median)**	**Range**
Concordant HIV− couples	10 (26%)					
Discordant[c]/Unknown[d] status	2 (5%)[c]/4 (10%)					
Current contraceptive use (women)	Condoms only 15 (39%); Dual method 4 (10%); Injection/DMPA 13 (34%); No modern method 5 (13%); Oral contraception 2 (5%); Bilateral tubal ligation 2 (5%); Pregnant 1 (2%)					
Covert contraception	11 (29%)					

[a]Difference between number of children from male and female perspectives due to polygamous marriages.

[b]From the perspective of participants about their own status.

[c]Discordant couples included one with female partner HIV+, one with male partner HIV+