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“It is my business”: A Mixed-Methods Analysis of Covert Contraceptive Use among Women in Rakai, Uganda

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Abstract

Objective(s)—Covert contraceptive use (CCU) is the use of family planning without a partner’s knowledge. This study sought to examine CCU prevalence among women living in Rakai, Uganda, predictors of CCU, and why women resort to CCU.

Study Design—We used data from women (15–49 years) currently using contraceptives (oral contraceptives, Depo Provera, implants, intrauterine devices, and periodic abstinence) during Round 15 (2011–2013) of the Rakai Community Cohort Survey (n=2,206). We utilized logistic regressions to analyze the association between self-reported CCU and current contraceptive method, sexual activity, experience of violence, and demographic data. We also used data from in-depth interviews (IDI) on HIV and reproductive health conducted in 2013–2016.

Results—CCU prevalence was 26%. In the multivariable model, being previously married (aOR=2.2 [1.7–2.9]), having no formal education (aOR=2.1 [1.1–3.9]), and experiencing physical violence (aOR=1.7 [1.3–2.2]) or having more than 1 sex partner (aOR=1.6 [1.2–2.2]) in the past 12 months were CCU predictors. Advancing past primary school decreased the odds of CCU (aOR=0.7 [0.6–0.9]). HIV was positively associated with CCU in the unadjusted model, but not the adjusted. In the IDIs, women primarily resorted to CCU because of discordant fertility desires—coupled with financial insecurity, negative stereotypes towards contraceptives use, deteriorating health, and familial pressure to reproduce. One woman employed CCU because she feared being ostracized from her community.

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Authors' Contributions: Craig Heck formulated the article’s research questions, conducted the main qualitative and quantitative analyses, and wrote the majority of the article. Stephanie Grilo assisted with qualitative and quantitative data analysis and drafting of the article. Neema Nakyanjo advised the design and implementation of the qualitative study and assisted with qualitative analysis. Xiaoyu Song and Tom Lutalo provided statistical and analytical direction; Tom Lutalo also led the design and implementation of the RCCS. John Santelli oversaw the design and implementation of both studies, provided guidance with the mixed-methods analysis, and assisted with writing this article.

Conclusions—CCU is common amongst users of contraception and is used to hide family planning from partners and communities. Women that diverge from Uganda’s cultural norms had higher odds of CCU.

Implications—Clinicians and practitioners should be aware of CCU among their patients and should educate women on the wide variety of contraceptive methods to help them decide if their current covert method is best for their health and safety.

Keywords

Covert; secret; contraception; HIV; family planning; reproduction

1. Introduction

Covert contraceptive use (CCU) refers to the use of contraceptive methods without a partner’s knowledge [1]. Generally, only certain methods of contraception may be used covertly, including: oral contraceptives, emergency contraceptives, Depo Provera (Depo), implants, intrauterine devices (IUDs), and periodic abstinence [1, 2]. Use of covert methods shifts control to the woman rather than the relationship dyad, allowing the woman to assert her fertility desires and intentions—albeit secretly.

Prior research illuminates women’s rationales for CCU. The first reason is discordant fertility desires and/or intentions between partners. Men may prefer larger families [3, 4] as they see it as recuperation of the paid bride price [1]; additionally, son preference acts as a catalyst for pregnancy due to the cultural and patrilineal importance of males [3, 5]. Thus, CCU allows women to control, time, and prevent their pregnancies, at their discretion. Secondly, partner disapproval of contraception is a contributing factor to the practice of CCU. In one study, men expressed beliefs that contraception encouraged infidelity, weakened their dominance over their wife/partner, led to infertility, and thwarted their own fertility desires [1]. The third factor is couples’ inability to communicate about family planning. In one DHS survey, women expressed that they were too modest to discuss family planning options with their partners or were fearful the topic would incite anger and violence within their partner, thereby endangering their safety [6].

Previous studies also illustrate the mechanisms and factors—risk or protective—that are associated with CCU. A qualitative study in the Nyanza province of Kenya found that HIV-positive women employed CCU to control their birth spacing when their fertility desires were in disagreement with their partner’s [7]. Some women cited polygyny as a mediating factor for increased fertility desires among women, as they feared their husband would seek out other wives/partners if they did not help their husband reach his desired family size [7]. Furthermore, a mixed-methods analysis in the Sunyani municipality of Ghana ascertained that CCU was common (34%), with the strongest drivers being marital status, religious faith, and fertility intentions [2].

In Uganda, the prevalence of CCU was last estimated in 1996 using the demographic and health survey (DHS) administered within Uganda’s Masaka and Lira districts [6]. The DHS

data showed that the prevalence of CCU was ~15%, with the majority of covert users residing in rural areas rather than urban city centers (18.2% vs. 6.5%, respectively) [6].

Prior quantitative studies have often used discordant responses regarding contraception as a proxy for CCU. This study measures CCU by directly asking female respondents if they are using their family planning method secretly. We supplement the quantitative analysis with qualitative data to describe the context of CCU. This novel approach allows us to examine not only the intra- and interpersonal factors that contribute to CCU, but the structural influences as well. Using a mixed-methods study design, we seek to answer three research questions: 1. What is the prevalence of CCU among women living in Rakai, Uganda; 2. What are the predictors for CCU in Rakai, Uganda; and 3. Why do women in Rakai, Uganda use contraception covertly?

2. Materials and Methods

Our study design uses data from two related studies, one quantitative and one qualitative, conducted in the Rakai district of Uganda. To capture the breadth of CCU, we examine survey responses from a demographic cohort—while the qualitative interviews elucidate the reasons why women in Rakai employ CCU.

2.1 Quantitative

We drew quantitative data from the Rakai Community Cohort Survey (RCCS), a longitudinal cohort in Rakai, Uganda tracked since 1994 by the Rakai Health Sciences Program (RHSP). The RCCS captures data about reproductive and sexual health decisions and outcomes, including HIV incidence and prevalence, sexual risk behaviors, relationship status, pregnancy history, contraceptive use, pregnancy intentions, and unmet need for contraception. Community members are offered the opportunity to participate in the dynamic community cohort by enrolling for free HIV testing and care at one of RHSP's mobile clinics. Previous RHSP studies have already extensively outlined the methods, logistics, and history of the RCCS [8, 9].

Each participant is administered a structured survey in Luganda, Rakai's native language, by a same-sex RHSP-trained interviewer in a quiet, private location at a central community hub. Participants entering the RCCS at Round 15 are administered the baseline survey, while current RCCS respondents are administered the follow-up survey.

For our analysis, we selected women currently using contraception from Round 15 (2011–2013) of the RCCS, which included an additional question about CCU, and examined contraceptive methods that can be used without a male partner's knowledge—as operationalized by the RCCS. The examined contraceptive methods included oral contraceptives, implants, Depo, periodic abstinence, and IUDs.¹ Since our focus is on current users of contraceptives, we excluded currently pregnant women. From 9,233 females, 3,264 used contraceptive methods, with 2,301 (70%) of those females being current users of an examined contraceptive method. 93 women did not provide a response to the

¹Henceforth, these five contraceptive methods are referred to as the “examined contraceptive methods.”

question pertaining to CCU, and 2 women provided invalid responses (i.e., they were asked about CCU without using one of the examined contraceptive methods), giving a final sample of 2,206 women.

Employment archetypes are categorized based on five industries: Agriculture, Housework, Professional, Service, and Other. Religion comprised of the predominant religious groups of the region—Catholic, Protestant, Pentecostal, Muslim, and other. We extracted religious affiliation from baseline responses. We constructed the physical abuse variable by collapsing six binary variables (In the past 12 months, have you ever been: pushed, punched, kicked, strangled/burned, threatened with a weapon, or been attacked with a weapon by any of your sex partners?) into a singular dichotomous (Yes/No) variable. A dichotomous variable for experience of sexual abuse consists of 3 variables (In the past 12 months, has a sex partner: used verbal threats, physical force, or other means to have sex or perform sexual acts when you did not want to?). A variable cataloging experience of verbal abuse in the past 12 months is also included in our analysis. Method of family planning utilized is categorized using the five examined contraceptive methods: oral contraceptives, Depo, implants, periodic abstinence, and IUDs. Religion and educational attainment are collected from the baseline survey from each respondent, and education is consolidated into three values: No education completed, primary education, post-primary education. Marital status is categorized as married, previously married, and never married. Finally, the number of sex partners in the past year is used to classify women as monogamous and those with more than one partner. HIV status is measured using two ELISA tests and a confirmatory HIV-1 western blot [10]. We collapsed age and number of living children into logical categories.

The primary outcome for this analysis is CCU among women currently using oral contraceptives, implants, Depo, periodic abstinence, or IUDs. Respondents who reply “Yes” to currently using any of these methods are then asked: “Does your partner know that you are using this method of family planning?” Answers are categorized as Yes, No, or Don’t Know. We did not ask this question to respondents who: are currently pregnant, discontinued an examined method, or reported using an unexamined contraceptive method. Therefore, we excluded them from our analysis.

Univariate analysis is used to analyze demographic characteristics and highlight how many women use contraception, how many use the examined contraceptive methods, and how many users utilize these methods covertly. We utilize simple logistic regression to elucidate significant bivariate associations between independent dichotomous and categorical variables and CCU. Forward selection is used to construct a preliminary multivariable model, using a p-value= 0.25 threshold. Once all of the covariates are significant at a 5% level of significance, the multivariable model is finalized.

2.2 Qualitative

We use qualitative data from two arms of the Prevention and Planning Linkages (Linkages) project, a 5-year mixed-methods study aimed at understanding how men, women, and couples in Rakai approach relationships, pregnancy planning, and fertility desires—in the context of a generalized HIV epidemic. The first arm explores fertility intentions among couples by asking them about their fertility desires; HIV testing, disclosure, and risk-taking

behaviors; contraceptive use; and current relationship context. The second arm examines fertility desires among women over time by inquiring about nine reproductive topics: children, marriage, and sexual experience; HIV testing and treatment; HIV's effect on their romantic relationship(s); HIV disclosure; fertility desires; contraception; relationship dynamics; multi-partner fertility; and HIV's effects on other aspects of life. Neither arm explicitly asks women about CCU. Both arms included HIV-positive and HIV-negative individuals.

Trained RHSP personnel purposively identified and recruited women from Round 16 (2014–2016) of the RCCS. The first study arm enrolled monogamous women based on how many children they had and the HIV serostatus of themselves and their partner. The second research arm recruited women based on how long they have known their HIV status and included both HIV negative and positive women. Both arms also took age into account when identifying eligible participants. Within these parameters, RHSP personnel selected fifty-three females—29 HIV-positive and 24 HIV-negative—for qualitative analysis.

Trained same-sex RHSP personnel collected qualitative data using semi-structured in-depth interviews conducted in a quiet, private location of the participant's choice, usually the respondent's home. To prevent stigma and bias, data collectors within both arms are blind to the participant's HIV status. Participants are remunerated 5,000 shillings (\$2.00) for their time.

We utilize open coding to analyze the qualitative transcripts [11]. We conducted quantitative data management, transformation, and analysis using SPSS v. 23.0.0.0 and used Dedoose v. 7.5.9 and NVivo v.11 to store and code the qualitative data.

2.3 Ethics

Trained RHSP personnel obtained written informed consent and assent from all participants in both the qualitative and quantitative studies. Emancipated minors (i.e., individuals aged 15–17 who were married or lived outside of their familial household) provided consent without their parent's consultation. The protocols were reviewed and approved by IRBs at Columbia University Medical Center in the United States and the Uganda Virus Research Institute.

3. Results

3.1 Quantitative Findings

The sample distribution of women for this analysis is found in Table 1. The sample was predominantly Catholic (64.1%), HIV-negative (76.%), and had completed primary education (59.6%); over half of the sample (56.5%) had between 1 and 3 children. Most respondents were married (75.5%), monogamous (89.1%), and used Depo (71.9%) as their contraceptive method. Participants also reported experiencing verbal (7%), physical (20.6%), or sexual abuse (11.5%) in the past 12 months.

CCU was common, with an overall prevalence of 26.2% among users of the examined contraceptive methods (calculation now shown). The prevalence of CCU was 17.7% among women who reported using any form of contraception (calculation not shown).

Bivariate analyses are presented in Table 1. Significant predictors of CCU were: being previously married (Odds Ratio [OR]=2.9), having no formal education (OR=2.8), having more than 1 sex partner in the past year (OR=2.4), having never married (OR=2.0), working in the service industry (OR=1.7), being HIV positive (OR=1.7), and experiencing verbal abuse, physical abuse, or sexual abuse within the past 12 months. Advancing past primary education protected women from CCU (OR=0.7).

Multivariable analyses yielded similar results: being previously married (Adjusted OR [aOR]=2.2), having never completed any level of schooling (aOR=2.1), having more than 1 sex partner in the past 12 months (aOR=1.6), and working in a non-traditional industry (i.e. Other) (aOR=1.5) remained predictors of CCU after controlling for other variables, albeit with weaker estimated effects. When holding the other covariates constant, physical abuse was the only violence variable that emerged as a predictor of CCU—and being non-married (aOR=2.0) and advancing past primary school (aOR=0.7) maintained their estimated effects. After controlling for other variables, the estimated effect of HIV status on CCU decreased (OR =1.7 [1.4–2.2] to aOR=1.2 [0.9–1.6]).

3.2 Qualitative Vignettes

The qualitative vignettes in Table 2 present all of the themes surrounding CCU disclosure that emerged from the transcripts. These passages describe why women resort to using contraception covertly, ranging from financial considerations to deflecting coercive behavior to achieving personal fulfillment; certain portions of the passages are bolded for emphasis.

The woman in Vignette 1 disclosed that her decision to use contraception covertly was informed by her family's financial insecurity. She is concerned about having more children as her partner can barely provide for their current family size, and she cannot support another child with her current income. To keep her family at a manageable size, she utilized contraception secretly.

In Vignette 2, the woman's religion complicated her relationship with contraception—covert or not. She believed that family planning discussions and use were forbidden among Born Again Christians, and due to the contradiction with her faith, she utilized contraception secretly to avoid being ostracized from her religious social network.

Negative stereotypes towards family planning methods and its use were illustrated in vignette 3: the woman's male partner believed that Depo use leads to diseases and other "bad things," effectively expressing his disapproval of family planning discussions and utilization.

In Vignette 4, the woman disclosed that her partner did not consistently use condoms—so she used Depo covertly to control the spacing of her children. She recognized that if she added to her family, she would not be able to provide ample love and care to her current children. She also noted that being in control of her birth spacing allows her to focus on her

work and that adding another child would not give her the luxury of rest and relaxation. Familial influences influenced the woman in vignette 5, but they were coercive and pervasive in nature. The respondent's husband and mother-in-law placed extreme pressure on her to birth another child, exclaiming that her willingness to do so is directly related to her love for her husband. The pressure was so severe that the woman was willing to endure her fear of needles to acquire Depo, as it is more discrete and reliable than her current method: oral contraceptives.

The woman from vignette 6 cited birth spacing as her reasoning for CCU: she candidly admitted that her parental capacity would be spread too thin if she added another child to the family—a concern that did not affect her husband, for he was persistent in his goal of expanding his family size. Lastly, the woman in vignette 7 credited her health, lack of energy, and positive HIV status as the reason for not wanting to produce more children, a stance that was discordant to her partner's fertility desires.

Overall, discordant fertility desires underpinned the covert use of contraception. The women in vignettes 1, 4, 6, and 7 expressed that they wished to delay or stop childbearing but their partner did not. Vignettes 1 and 4 showed that the condom-negotiation process is often precluded by their partner's outright refusal to use male-initiated barrier methods (i.e., the male condom).

4. Discussion

4.1 Summary/Interpretations

In this paper, we found that CCU is relatively common in Rakai, Uganda: among our sample, 26.2% of women using an examined contraceptive method disclosed that they were using their contraception covertly. The prevalence of CCU among all contraceptive users—both examined and not—was 17.7%, which is slightly higher than the last study done in Uganda in 1996 (15%) [6]. The predictors we discovered—working in a non-traditional industry, having no formal schooling, non-monogamy, being non-married or previously married, having more than 1 sex partner, and experiencing physical abuse in the last 12 months—indicates that users of the examined contraceptive methods who diverge from Uganda's cultural gender norms (i.e., monogamy, marriage, and subsistence employment) have higher odds of secretly using contraception compared to their “traditional” counterparts [12–15]. Given that Uganda's social and cultural landscape is largely molded and enforced by hegemonic masculinity, these CCU predictors are enlightening yet unsurprising [16]. This new insight broadens the understanding of CCU among women in rural, southern Uganda—for the last assessment of CCU in the region did not statistically test for associative factors or predictors [6]. Compared to a recent study in West Africa, our findings support the notion that single women have a higher likelihood of practicing CCU—but our discovery that education, or lack thereof, was a predictor of CCU conflicts with the Ghanaian study [2].

Additionally, we found that a positive HIV diagnosis is a bivariate but not a multivariable predictor of CCU. Previous research surrounding HIV and CCU has primarily focused on barrier methods [17, 18]. However, due to our study design, we cannot infer the causal

directionality of this association. Although, some potential explanations for this association include a lack of conversations pertaining to sex/reproduction [6, 19], failed negotiations for barrier methods [19, 20], or polygyny/their partner having extramarital sex [19].

Surprisingly, parity was not associated with CCU. We believed that women with more children would be more likely to employ CCU as a way of preventing pregnancy, but our quantitative analysis does not corroborate this connection. When accounting for the number of living children, CCU is relatively constant—which supports the current understanding that no matter the family size, Ugandan women are under constant pressure to produce children [3, 4]. The qualitative vignettes also supported this understanding—as many of the male partners sought to expand their family size even when it went against their financial standing and/or their partner's wishes.

Although religion was not associated with CCU in our quantitative findings, vignette 2 provided insights about the intersection of her religious identity and her identity as a woman. Vignette 2 also highlighted that women employ CCU to hide family planning not only from their partners but the community as well. This finding expands the scope of CCU past the relationship dyad to a woman's social and societal landscape—adding an additional layer of nuance to the multidimensional phenomenon. Although the vignette only offered us a glimpse into this unique form of CCU, its emergence underscores a need for further research to understand the underpinnings of this secretive practice.

Uganda has made strides towards gender equality over the past 20 years, such as increased governmental participation and school enrollment [21]. Despite these advancements, gender inequality still permeates Uganda's political, economic, and societal strata due to inconsistencies in legislation, policies, and practice [22]. Meaning, women still lack agency and equal representation at all levels of regional and national development [21, 22], which could explain the slight increase in CCU within the region. Hopefully, Uganda's commitment to ending gender discrimination and promotion of full participation narrows and—eventually—eliminates this gendered divide [23].

4.2 Limitations

Because this study utilized a cross-sectional study design, we could not assess causality. The in-depth interviews did not ask directly about CCU; it was a topic that organically emerged from the conversation. Directly asking may have produced additional insights. Due to the survey's structure, we could not ask non-monogamous women if CCU varied by partner. This information could have added additional nuance to our analysis. The survey's structure also did not allow us to examine what contraceptive method pregnant women were using at the time they got pregnant—which would allow us to research if covert use, or lack thereof, was any way associated with their pregnancy. Additionally, we lacked data on certain reproductive and sexual predictors—such as the preferred length of spacing until their next pregnancy, engagement in transactional sex work, and data on partners' fertility desires; these may have provided additional insights.

4.3 Implications

Our findings suggest that women employ CCU to hide family planning from their partners as well as the community. This information can help programmers, clinicians, and family planning practitioners tailor clinical care and community mobilization campaigns to provide welcoming and inclusive care. It also underscores the importance of confidentiality and discretion when providing reproductive healthcare, for a woman may be trying to hide her contraception from both her partner and the community. Moreover, clinicians and practitioners should be aware that CCU may be common and provide education to women on the wide variety of contraceptive methods to help them understand if their current method is best for their safety, health, and well-being. Additional research, preferably using longitudinal designs, could provide useful insights on how the introduction of new or modern contraceptive methods affect CCU. Lastly, this article demonstrates how a mixed-methods approach is useful in documenting the causes of CCU.

CCU is a means by which women regain some of their reproductive autonomy. Clinicians and family planning practitioners should be cognizant of this vulnerable population because they have unique needs that are vital to their health, safety, and well-being.

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Bivariate and multivariable analysis of predictors of covert contraceptive use among women who use select contraceptive methods in Rakai, Uganda

Table 1

Variable	Variable Subcategory	Total (n=2206)	Covert Use		Unadjusted OR ^a (95% CI ^b)	Overall p-value	Adjusted OR ^a (95% CI ^b) (n=2131)
			Yes (%)	No (%)			
Age	15–25	672	183 (27.2)	489 (72.8)	1.1 (.8–1.3)	.55	-
	26–36	1176	297 (25.3)	879 (74.7)	1.00		-
	37–49	358	98 (27.4)	260 (72.6)	1.1 (.854–1.4)		-
Employment	Agriculture	876	181 (20.7)	695 (79.3)	1.00	<.00*	1.00
	Housework	212	62 (29.2)	150 (70.8)	1.5 (1.1–2.2)		1.2 (0.9–1.9)
	Professional	255	58 (22.7)	197 (77.3)	1.1 (.80–1.5)		1.3 (0.8–1.7)
	Service Industry	697	220 (31.6)	477 (68.4)	1.7 (1.4–2.2)		1.3 (1.0–1.7)
	Other	156	56 (34.3)	100 (65.7)	2.0 (1.4–2.8)		1.5 (1.0–2.3)
Religion	Catholic	1414	369 (26.1)	1045 (73.9)	1.00	.71	-
	Protestant	342	89 (26)	253 (74)	1.0 (.7–1.3)		-
	Pentecostal	68	20 (29.4)	48 (70.6)	1.1 (.6–2.0)		-
	Muslim	334	91 (27.2)	243 (72.8)	1.0 (.8–1.4)		-
	Other	15	3 (20)	12 (80)	.7(.2–2.5)		-
Highest level of education attained	None	50	26 (52)	24 (48)	2.8 (1.6–5.0)	<.00*	2.1 (1.1–3.9)
	Primary	1315	363 (27.6)	952 (72.4)	1.00		1.00
	Post Primary	774	170 (22)	604 (78)	.7 (.6–.9)		0.7 (0.6–0.9)
Number of living children	0	69	20 (29)	49 (71)	1.0 (.6–1.8)	.14	-
	1–3	1247	345 (27.7)	902 (72.3)	1.00		-
	4–6	690	162 (23.5)	528 (76.5)	.8 (.6–1.0)		-
HIV Status	>6	165	44 (26.7)	121 (73.3)	.9 (.6–1.3)		-
	Positive	460	165 (35.9)	295 (64.1)	1.7 (1.4–2.2)	<.00*	1.2 (0.9–1.6)
	Negative	1688	404 (23.9)	1284 (76.1)	1.00		-
Contraceptive Method Used	Oral Contra	267	66 (24.7)	201 (75.3)	.9 (.6–1.2)	.47	-
	Depo	1587	412 (26)	1175 (74)	1.00		-
	Periodic Abstinence	104	29 (27.9)	75 (72.1)	1.1 (.7–1.7)		-
	IUD	108	38 (35.2)	70 (64.8)	1.5 (1.0–2.3)		-

Variable	Variable Subcategory	Total (n=2206)	Covert Use		Unadjusted OR ^a (95% CI) ^b	Overall p-value	Adjusted OR ^a (95% CI) ^b (n=2131)
			Yes (%)	No (%)			
Marital Status	Implants	140	33 (23.6)	107 (76.4)	.8 (.5–1.3)		-
	Married	1665	353 (21.2)	1312 (78.8)	1.00	<.00*	1.00
	Previously Married	371	164 (44.2)	207 (55.8)	2.9 (2.3–3.7)		2.2 (1.7–2.9)
# of sex part in last year	Never Married	170	61 (35.9)	109 (64.1)	2.0 (1.4–2.9)		2.0 (1.4–2.9)
	More than 1	220	96 (43.6)	124 (56.4)	2.4 (1.8–3.2)	<.00*	1.6 (1.2–2.2)
	1	1966	467 (23.8)	1499 (76.2)	1.00		1.00
Experienced verbal abuse in the past 12 months	Yes	154	51 (33.1)	103 (66.9)	1.4 (1.0–2.0)	.03*	-
	No	2035	513 (25.2)	1522 (74.8)	1.00		-
Experienced physical abuse in the past 12 months	Yes	455	163 (35.8)	292 (64.2)	1.8 (1.4–2.3)	<.00*	1.7 (1.3–2.2)
	No	1734	401 (23.1)	1333 (76.9)	1.00		1.00
Experienced sexual abuse in the past 12 months	Yes	253	89 (35.2)	164 (64.8)	1.6 (1.2–2.2)	<.00*	-
	No	1936	475 (24.5)	1461 (75.5)	1.00		-

* p-value <0.05

^aOR = Odds Ratio^b95% CI = 95% Confidence Interval

Table 2

Qualitative Passages Exploring The Reasoning Behind Covert Contraceptive Use

No.	Theme(s)	Descriptors	Vignette
1	Financial Security	Age: 41 HIV+	<i>I tried [to talk to him about using condoms], but he is a person who want[s] to have a child with me. He could most of the time tell me that “let us have a child” so having a child is something he could think about a lot...I refused having children with him because I felt like I am not financially stable to take care of another child. I did not give my first child enough care, so I think I am not ready enough to have another child... comparing with what he provides for me which is not enough, this makes me think that he will not give the child enough care. It means that my contribution will be necessary and I feel I am not yet financially better...when he is sometimes away from home for about six months, he may go for work for about four or six months. So when he is around, I can take a pill or go for depo injection. If he is going to stay home for about a month, I go get depo injection...I only take pills if he is going to stay for three or two days... He is not aware of [these methods]. It is my business. I don't tell him such things because he wants to have a child and will ask me why I have not given him a child. That is my business.</i>
2	Religion	Age: 38 HIV+	<i>I just feel I don't want to have more children. [I] sat down with my husband and prayed about not getting pregnant any more. We prayed to God and said that instead of getting many pregnancies and aborting them, it is better if we prevent getting pregnant. So I decided to start using birth control. I did not talk about it with any church member. I decided to start using birth controls as an individual... We did not talk about [spacing] because as Born Again Christians, we are not so much attached to family planning issues, the church discourages such. It is bad in that it prevents God's plans...</i>
3	Stereotypes	Age: 33 HIV-	<i>Regarding spacing children, it is something I do on my own. I don't plan that with him...I thought if I tell him, he would still not accept...I always see him talk ill or talk against people who use family planning methods... We can be chatting and he starts saying that “look at that person's wife she is on depo injection and yet those injections cause a lot of diseases and so many bad things” he says such things.</i>
4	Career+Family	Age:36 HIV+	<i>No. [His fertility desires] completely has no effect/influence on my desire for children. If I produce the number of children I want, I cannot be coerced or forced to have another child/children if I don't want. ... Do you mean if I go for family planning he will escort me? For me, I just go for depo without him knowing and I come back home and remain silent about it. When he pesters me, I just tell him that I also don't know why I cannot get pregnant until years go by...I sometimes remind him to use a condom...[b]ut sometimes he refuses and insists on having sex and when we have sex, we do not use a condom...So I am the one to determine whether to have a child or not...The gap enables me to help this child grow well and have ample love from me the mother. I am also able to do my work properly without many things disturbing me... if I had her and a baby, I would be very busy without any peace.</i>
5	Familial Pressure	Age: 22 HIV+	<i>We were not staying together at first. So, whenever we could meet I could take some pills [to avoid pregnancy]...[H]e used to pester me to get pregnant. He even reached an extent of taking me to his mother to report me that I am refusing to get pregnant. His mother told me that “if you don't love my son and you know you will not give him children, tell him the truth”...I started living with him after getting pregnant, I have been using pills sometimes. I don't know which method I will use in the future. In my life, I fear being injected but if it is the best solution, I will go for Depo Provera.</i>
6	Birth Spacing	Age: 36 HIV+	<i>He does not talk about [spacing]. If he was really concerned about spacing the kids, he would not be pestering me to have another child now yet the one I have is just nine months old. Is he giving me space? The baby is not yet a year old but he is telling me that he wants to have another child. There is no spacing he is giving me. I do spacing on my own without his knowledge. He never wanted me to use any family planning method...[because] he wants me to give him another child... I don't want to have more children because I told you that the children I have right now are the children I can take care of... he wants to have more children with me but I don't show him that I will not give him another child. It will only happen if the depo injection I am using fails me.</i>
7	Health	Age: 42 HIV+	<i>I did not tell him [that I was using Depo], he only saw me becoming thin and asked me what had happened to me. I could not answer him... [d]uring that time, he did not want family planning method. It was my own decision and he did not know about it. He very much wants to have more children, but for me I don't want [more]...I no longer have energy...I don't have the strength to have another child but since now that I have HIV, I cannot attempt to have another child.</i>