

Research Article

“Choosing Peace” or “Living in Fear”: Relational Mechanisms of Family Planning Non-Use Among Married Women in Bo City, Sierra Leone

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Background: Despite near-universal awareness of family planning in Bo City, Sierra Leone, unmet need remains high among married women. Relational mechanisms influence reproductive health decisions in many African countries, yet little qualitative research has examined the specific relational barriers and facilitators to family planning among married women in Sierra Leone.

Methods: This qualitative study used in-depth interviews with married women (n=15), male partners (n=3), and community leaders (n=2), and focus group discussions with married women (n=2 groups), male partners (n=1 group), community leaders (n=1 group), and healthcare providers (n=1 group). Data were collected between February 24-28, 2025, and analysed using thematic analysis within a relational autonomy framework, following COREQ guidelines.

Results: Six relational mechanisms were identified. Partner alignment enables use through spousal cooperation, often triggered by economic pressures. The male veto blocks use through terminal spousal opposition at individual, interpersonal, and community levels. Women navigate these constraints through two distinct strategies: adaptive preferences, reframing non-use as voluntary choice to preserve household harmony (“choosing peace”), and covert practice – secret injectable use with persistent anxiety (“living in fear”). Religious interpretive variation shapes whether faith supports or opposes use. Extended family and polygamous dynamics create surveillance and fertility competition that constrain autonomy. Economic independence emerged as a cross-cutting enabling pathway.

Conclusion: Reproductive health decisions are fundamentally relational. Providers should routinely screen for spousal opposition, develop confidentiality protocols for covert users, and offer couple-based counselling addressing shared economic concerns. Training providers to identify and respond

to relational barriers is a practical strategy for reducing unmet need where family planning knowledge does not translate into practice.

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Key Messages

- **What is already known on this topic.** Quantitative studies in sub-Saharan Africa have established that spousal dynamics are the dominant influence on reproductive decision-making, yet the specific mechanisms through which husbands block or enable use, and how women navigate constrained choices, remain underexplored in Sierra Leone.
- **What this study adds.** This qualitative study identifies six relational mechanisms explaining the family planning knowledge-practice gap among married women in Bo City, including two novel strategies, adaptive preferences (“choosing peace”) and covert practice (“living in fear”), through which women navigate spousal opposition.
- **How this study might affect research, practice or policy.** Findings suggest that providers should screen for spousal opposition, develop confidentiality protocols, and offer couple-based counselling addressing economic concerns. Training providers to identify relational barriers offers a practical strategy for reducing unmet need.

Introduction

Despite global increases in contraceptive use, sub-Saharan Africa has the lowest modern contraceptive prevalence rate. ^[1] In Sierra Leone, contraceptive prevalence increased from 7% in 2008 to 21% in 2019, yet unmet need in Bo District remains 27%, the highest in the country. ^[2] While awareness of family planning methods is near-universal, a persistent gap between knowledge and practice characterises reproductive health in Sierra Leone. ^[2]

Quantitative research has established that spousal dynamics are the dominant influence on reproductive decision-making across sub-Saharan Africa. ^{[3][4]} However, the mechanisms by which these dynamics operate – how husbands block or enable use, how women navigate constrained choices, and why some women adopt covert practices – remain underexplored. ^[5] Qualitative evidence on how women navigate spousal opposition to family planning in West Africa is limited. ^[6]

In Sierra Leone, McLean and Thulin documented male involvement in contraceptive decisions, ^[7] while Yillah et al. examined religious leaders' views on family planning. ^[8] However, no study has provided an in-depth qualitative exploration of the full constellation of relational mechanisms – partner alignment, male veto, adaptive preferences, covert practice, religious interpretive variation, and extended family dynamics – as experienced by married women themselves.

This study addresses this gap by exploring the relational mechanisms that explain why married women in Bo City do or do not use family planning despite high awareness, and how they navigate these relational dynamics. Guided by relational autonomy theory, ^[9] this qualitative study employed in-depth interviews and focus group discussions to identify the patterned social processes that enable or constrain family planning use among married women.

Methods

Study Design and Setting

This qualitative study used an interpretive design, including in-depth interviews (IDIs) and focus group discussions (FGDs). The study was conducted in Bo City, one of the largest cities in Sierra Leone, with a population of 223,075, of which 118,621 were females. ^[10]

Researcher Positionality and Reflexivity

The first author is a female Sierra Leonean PhD candidate who previously worked in reproductive health programming in Bo District and is currently a lecturer and researcher. Before the study, she had no contact with any participants. A reflexive journal was maintained throughout data collection and analysis, with debriefing sessions with co-authors to discuss and bracket biases. Member checking was carried out with five participants, who confirmed that emerging themes reflected their experiences.

Sampling and Recruitment

Purposive sampling with maximum variation was used to recruit a diverse group of women of reproductive age. ^[11] Inclusion criteria for women were: married or cohabiting, aged 15–49 years, resident in Bo City for at least six months. Variation was sought across age (15–24, 25–34, 35–49 years), education (none, primary, secondary, tertiary), parity (0–2, 3–4, 5+ children), and contraceptive use status (current, past, never users).

Sample size was determined by thematic saturation, defined as the point at which no new themes emerged from consecutive interviews. ^[12] A total of 20 IDIs and 5 FGDs were conducted. Only three women refused to be interviewed because they complained about time availability.

Data Collection

IDIs and FGDs took place in health posts, community health centres, and participants' homes to ensure privacy. IDIs and FGDs were conducted by four trained female and male interviewers matched to participants by gender, excluding the lead author, who had a minimum degree of M.Sc. The lead author is a lecturer, and the other three researchers are assistant researchers of the institute. All interviewers underwent a three-day training session on study objectives, ethical issues, and topic guides. IDIs lasted approximately 45–60 minutes; FGDs lasted 60–90 minutes. Sessions were conducted in Mende, Temne, or Krio. A pilot study was conducted with ten women from Mokonde in Moyamba District to refine topic guides. Data collection took place over one week in February 2025.

All sessions were audio recorded, with field notes capturing nonverbal behaviours and setting observations. Participants gave verbal consent before each session and were informed that sessions would be recorded, transcribed verbatim, and used for analysis.

Data Analysis

Audio recordings were transcribed verbatim in the original language and translated into English. A third bilingual researcher verified one-third of transcripts for accuracy.

Coding was conducted in parallel by two researchers using a hybrid approach: deductive coding based on relational autonomy theory and inductive coding to identify emergent themes. Six deductive codes and 57 inductive codes were generated. Researchers achieved 92% agreement on 20% of the data; discrepancies were discussed and resolved.

Thematic analysis followed Braun and Clarke's six stages: familiarisation, initial coding, theme searching, theme reviewing, theme defining and naming, and writing up. ^{[13][14]} Themes were analysed for patterned social processes, actors involved, whether they enabled or constrained action, and their interrelationships, revealing six relational mechanisms. A reflexive journal was maintained throughout. Analysis followed COREQ guidelines. ^[15]

Results

Six relational mechanisms explaining the knowledge–practice gap in family planning were identified and are presented in Table 1.

Mechanism	Level of Influence	Key Pattern	Primary Effect
Partner Alignment	Couple	Open communication, joint decision-making	Enables sustained use
Male Veto	Couple/Individual/Community	Terminal spousal opposition regardless of women’s knowledge	Blocks use entirely
Adaptive Preferences	Individual	Reframing acquiescence as active choice (“choosing peace”)	Strategic non-use
Covert Practice	Individual/Couple	Secret injectable use with fear of discovery	Use under constraint
Religious Interpretive Variation	Community/Individual	Selective emphasis of teachings	Both barrier and enabler
Extended Family and Polygamous Dynamics	Household/Community	Maternal surveillance; co-wife fertility competition	Constrains autonomy

Table 1. Summary of Six Relational Mechanisms by Level, Pattern, and Effect

Partner Alignment – Enabling Use Through Communicative Autonomy

Partner alignment was observed in households where husbands managed resources and were concerned about family well-being. Husbands communicated with wives about household issues, and they jointly made decisions about family planning. Economic triggers, particularly school fees, led to changes in women’s knowledge translating into use.

“My husband supports the idea of family planning because he thinks that if we plan our family well, we will be able to raise our children better. We talked about family planning at home, and my husband agreed with me.” (IDI, Age 27, 3 children, current user)

A focus group participant explained how economic pressures triggered the shift:

“When my husband saw that we could not afford to pay for the school fees of all our children, he then told me that I should stop having children so that we could better raise the children we already have. So, that was how I started using the injection.” (FGD, Married woman, 4 children)

Healthcare providers confirmed this pattern:

“Women who come with their husbands are the ones who continue using the methods. Those who come alone will use a method once or twice and then stop, because when the husband is there, he hears the health education and he understands.” (FGD, Healthcare provider, female nurse)

Male Veto – Blocking Use Through Terminal Opposition

The most reported mechanism of non-use was the male veto, operating at individual, interpersonal, and community levels. Among 15 women interviewed in depth, the 7 non-users all cited spousal opposition as the primary reason for non-use. Several women demonstrated high knowledge yet remained non-users.

“I know about the pill and the implant. My friend uses it, and she is fine. But my husband says if I go to the clinic for that, he will know and he will send me away. So, I do nothing.” (IDI, Age 31, 5 children, non-user)

At the interpersonal level, the veto operated through anticipated opposition:

“I don't even ask him. I know what he will say. He will say I am trying to kill his children. So, I don't bring it up with him.” (IDI, Age 29, 4 children, non-user)

At the community level, religious leaders and male peer networks reinforced the veto:

“In our faith, children are a blessing from God. To prevent them is to question God's will. The husband is the head of the household. If he says no, then it is no.” (IDI, Community religious leader, Imam)

Adaptive Preferences – “Choosing Peace”

Adaptive preferences occurred when women reframed acquiescence to spousal opposition as a deliberate choice to preserve household harmony.

"I am not using family planning because of my husband. For me, it is better to 'choose peace' in my home than to go against his wishes. It is still my choice, even if it's not the one I would make on my own." (FGD, Married woman, 4 children, non-user)

Women explicitly rejected characterisation as "forced" or "coerced":

"Nobody is forcing me. I am choosing this. If I went to the clinic, my husband would be angry. There would be fighting in the house. I don't want to have fighting in my home. So, I choose peace." (IDI, Age 34, 6 children, non-user)

Covert Practice – "Living in Fear"

A small group of women practised covert contraceptive use, primarily using injectable methods that could be concealed from partners. This strategy enabled contraceptive action but came with substantial psychological costs.

"Even though he has never noticed, I am always afraid that when he looks at me, he will notice that I am using it." (IDI, Age 29, 2 children, covert user)

"I go to the clinic when he is at work. I tell him that I'm going to the market... he would be very upset if he knew I am using family planning. I don't know what he would do." (IDI, Age 34, 3 children, covert user)

The psychological burden was considerable:

"Every time he touches me, I think: does he know? Can he feel it? I cannot relax. But I cannot stop because I cannot have more children." (IDI, Age 32, 4 children, covert user)

Healthcare providers were aware of covert use but faced ethical dilemmas:

"Some women come and say: 'Please do not write this in my card. Do not tell anyone.' We know the husband does not know. What can we do? If we tell the husband, she will stop coming. If we don't tell, we are keeping a secret. We choose to keep the secret because at least she is using something." (FGD, Healthcare provider, community health officer)

Religious Interpretive Variation – Faith as Both Barrier and Enabler

Religious influences operated through several channels with significant variation within traditions. While some Muslim women expressed strong opposition to family planning, others practised it secretly.

“My religion forbids it; it is not good in the eyes of God. Whoever uses family planning is a murderer, according to the Quran.” (IDI, Muslim woman)

However, Christian women described religious framing that supports family planning as responsible parenting:

“The reason I support family planning is that my religion is Christianity, and I believe that family planning helps to reduce unwanted pregnancies and helps people to be able to provide for the children they have.” (IDI, Christian woman)

Muslim women practising covertly described this tension:

“We are Muslim, but I use it anyway. I don't tell anyone. Not my husband. Not my friends. Not the Imam. I just go to the clinic and keep it to myself. If it is indeed wrong, God will forgive me.” (IDI, Muslim woman)

Extended Family and Polygamous Dynamics – Surveillance and Competition

Extended household structures, particularly residence with mothers-in-law, created social surveillance that constrained family planning autonomy:

“My mother-in-law lives with us. She watches everything I do. When I tried to go to the family planning clinic, she asked where I was going. When I told her, she was angry. She said I was trying to kill her grandchildren. She told my husband. Now I cannot go openly.” (IDI, Married woman)

In polygamous unions, women described intense pressure to bear children as a form of competition with co-wives:

“For us, having a co-wife, you compete with the other wife. If she has more children, you feel pressure. People will say she is more fertile than you. The husband will favour her. So, you want to have as many children as possible, even if you are tired. Family planning is seen as giving up in the competition.” (IDI, Age 38)

Women in nuclear households described greater freedom, serving as an important disconfirming case:

“When we moved to our own house, everything changed. No mother-in-law watching. No aunties commenting. My husband and I could decide together without interference. That is when I started using family planning.” (IDI, Married woman)

Cross-Cutting Theme: Economic Independence as an Enabling Pathway

Economic independence emerged as a cross-cutting factor that enabled women to overcome both male veto and extended family opposition:

“With the money I earn from my job, I can visit the clinic anytime without asking my husband or anyone for transportation fare or service cost. When I was not working, I had to beg for money to go to the clinic. Sometimes he would say no. Now I can just go.” (FGD, Employed woman)

Discussion

This qualitative study explored the knowledge-practice gap in family planning among married women in Bo City, Sierra Leone. Six relational mechanisms were identified across individual, couple, household, and community levels.

Partner alignment was identified as a positive mechanism enabling family planning practice. Research from Uganda and Kenya shows that communication and joint decision-making are critical for women to access and use family planning methods. ^{[16][17]} However, in Bo City, partner alignment was driven by economic concerns, such as school fees and food security, rather than health messaging alone. This suggests that couple-focused counselling should address shared economic goals.

The male veto – an absolute barrier to family planning use – is well-documented across sub-Saharan Africa. ^{[18][19]} In Nigeria, a significant proportion of men oppose modern family planning use by their wives. ^[20] In Sierra Leone, men generally act as final decision-makers regarding wives’ contraceptive use. ^[7] Our study extends existing knowledge by outlining the multi-level nature of the male veto – individual (husband’s beliefs), interpersonal (wives’ anticipated opposition), and community (enforcement by peer groups and religious leaders).

Women navigated the male veto through two distinct strategies. Adaptive preferences involved psychological ‘adjustment’ to practices not chosen; women reframed non-use as voluntary to preserve household harmony (“choosing peace”). Covert practice involved ‘fear’ – fear of being ‘found out’ by husbands, mothers-in-law, co-wives, or neighbours (“living in fear”). These secret practices exposed users to great risk, including loss of housing, livelihood, marriage, and even life. Silverman et al. found that women across sub-Saharan Africa resist reproductive coercion through covert contraceptive use

despite concurrent forms of violence. ^[5] Our study contributes by documenting the psychological costs of covert use – the persistent anxiety of discovery that women described.

Religious influences on family planning choices vary. In Nigeria, Kunnuji examined religion's influence on reproductive health outcomes, ^[6] while in Ethiopia, Kebede et al. studied the relationship between religion and family planning. ^[21] These studies found that Catholics opposed modern contraceptives, while Pentecostals and some Muslims were more accepting of birth spacing. In our study, while some Muslim women expressed strong opposition, they practised covertly, indicating that religion was not the only factor influencing choices.

Extended family surveillance and polygamy created barriers to family planning. Research in Ghana found that women in polygynous marriages had 19% lower odds of modern contraceptive utilisation compared to those in monogamous marriages. ^[22] Women in nuclear households in our study reported greater autonomy, confirming that extended-family co-residence, rather than marriage type per se, acts as a barrier to reproductive decision-making.

Economic independence emerged as a cross-cutting enabling pathway. Women with independent income demonstrated greater reproductive autonomy, consistent with research showing that economic resources enable women to overcome structural constraints.

Implications for Clinical and Service Delivery Practice

These findings offer actionable guidance for providers delivering family planning services in urban Sierra Leone and similar settings.

Providers should first routinely assess for spousal opposition during consultations. Asking a simple screening question – “If your husband knew you were here today, what would happen?” – can identify women at risk of covert use or those who may discontinue methods due to anticipated opposition. Routine screening for relational barriers should be integrated into family planning counselling protocols.

Also, they must develop clear protocols for maintaining confidentiality, particularly for women who disclose covert use. Our findings show that providers face significant ethical dilemmas when they know a woman is using contraception without her partner's knowledge. Clinics should establish guidelines that balance the duty of confidentiality with the need to support women's autonomous reproductive decision-making. This is a pressing training need for frontline staff, as current practice is managed informally without clear institutional guidance.

Furthermore, couple-based counselling should be offered where feasible, but providers should recognise that economic concerns, not just health concerns, drive partner alignment. Counselling messages that address shared financial goals (e.g., affording school fees) may be more effective than messages focused solely on health benefits.

Moreover, providers should expand their referral networks to include community-based economic empowerment programmes, as women with independent income demonstrated greater reproductive autonomy in our study.

In addition, service delivery models should accommodate the social realities of extended family and polygamous households. Offering discreet clinic hours, ensuring privacy during consultations, and training staff to ask about household dynamics can help women navigate surveillance from mothers-in-law and co-wives.

Finally, our six relational mechanisms could inform the development of a simple clinical screening tool. Providers could assess women's relational context by asking: Does your partner support family planning? Would you face consequences if he knew you were using contraception? Do you live with extended family who influence your decisions? Do you have independent access to money? These questions would allow providers to tailor counselling, offer appropriate confidentiality protections, and connect women to additional support.

Strengths and Limitations

This study has several strengths. The conceptual framework of relational autonomy structured the study, moving beyond description to explain how social structures shape family planning practices. Triangulation across multiple participant types strengthened credibility. A disconfirming case study of women in nuclear households provided further credibility. Researcher reflexivity was practised through journaling, debriefing, and member checking. Findings were presented transparently, adhering to COREQ guidelines. ^[15]

However, findings could not be verified by husbands of all participants. There is potential for social desirability bias, especially regarding covert use. The cross-sectional design cannot show how relational mechanisms change over time. The urban setting may limit transferability to rural areas.

Future research should investigate relational mechanisms over time using longitudinal designs. Dyadic study designs could verify partner concordance. Findings should be transferred to other contexts, such as

rural settings or settings with different religious compositions. Intervention research evaluating programmes that address relational mechanisms would be highly valuable.

Notes

Running title: Relational Mechanisms of Family Planning Non-Use

Statements and Declarations

Funding

No specific funding was received for this work.

Potential Competing Interests

No potential competing interests to declare.

Ethics

The study adhered to the principles of the Declaration of Helsinki. Ethical approval was obtained from the University's Research and Development Directorate and Postgraduate Review Board (NU/R&D/REC/25.01.25), and administrative clearance was secured from the Bo District Health Management Team. Informed consent was obtained from all participants, and data were anonymised using pseudonyms.

Patient and Public Involvement

Patients and the public were not involved in the design, conduct, or dissemination of this study. This research was initiated by the academic research team. However, the research question was informed by the first author's previous work in reproductive health programming in Bo District, where community perspectives on family planning barriers were consistently raised by women and community leaders. Findings will be disseminated through community feedback sessions in Bo City and through summary reports shared with the Bo District Health Management Team.

Patient Consent for Publication

Not applicable.

Data Availability

The datasets generated and/or analysed during the current study are not publicly available due to the sensitive nature of the data and participant confidentiality, but are available from the corresponding author on reasonable request.

Author Contributions

VNB: designed the study, methodology, data collection, analysis, and wrote the original draft. HBSK: provided supervision of the study and methodology and reviewed/edited the early draft. AJA: data collection, analysis, and reviewed/edited the manuscript. All authors have carefully reviewed the final manuscript and approved it.

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Declarations

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