



Commentary

Covert family planning as a symbol of agency for young, married women

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Family planning has long been seen as both a marker and a potential driver of women's autonomy and overall population health. Family planning is strongly linked to child and women's health outcomes, and tends to be better for nearly every household measure [1,2].

Yet, for many across the globe, access to family planning is limited. This is compounded by situations where women live with intimate partner violence (IPV) and may also be stopped from, or feel unable to, access family planning. Moreover, young women in many settings are coerced by partners and families into making fertility decisions against their will, which is termed "reproductive coercion" [3].

There is already much we know about the negative impacts of IPV on family planning and reproductive outcomes [4]. However, there is also conflicting evidence on the impact of IPV on modern contraceptive use: some studies demonstrate that IPV increases modern contraceptive use, while in others IPV decreases it [5].

Silverman, et al. [6], do an excellent job parsing out how reproductive control and IPV are related to family planning use in a distinct group of young women: those who have married as adolescents. This population is crucial to explore not only because of the health and social outcomes related to early marriage [7], but also because future efforts to achieve family planning will need to be tailored to the special needs of this group. The authors interviewed 1072 young women who married as adolescents using a clustered sampling approach in 16 villages of the Dosso region in Niger, Africa.

Importantly, Silverman [6] and colleagues ask women about whether their husbands know they are using modern contraception ("overt use") or whether they hide the use from them ("covert use"). While there is no clear association between family planning and IPV or reproductive coercion using the entire sample, there are critical

independent associations when covert use is isolated. Covert use is associated with a young woman experiencing any physical IPV, any sexual IPV or any reproductive coercion. In short, these young women are actively hiding their use of contraception from their husbands when they experience violence and coercion.

This analysis has important implications. First, it demonstrates how many young women strategically seek to take control of their own lives, even in challenging contexts. Their agency in choosing to use and hide contraceptive use from their husbands emphasises how women actively struggle to create meaningful lives even in the context of violence and control [8]. It also suggests that health programs for some young women may need to support their desire to discretely choose their own method of family planning. Indeed, hidden forms of contraception, like injectables, may be particularly desirable for this group and need to be made more available.

Second, much work around women controlled HIV-prevention technologies – particularly microbicides and pre-exposure prophylaxis (PrEP) – have shown limited applicability to young women's lives [9]. These require frequent use to be effective. Silverman et al.'s [6] work suggests that one reason gel microbicides and PrEP in the form of pills are not appropriate for young women, is because they are tricky to use covertly. As a new generation of long-lasting HIV-prevention and treatment technologies for women emerge [10], it may be that young women are more able to use these to take control of their sexual health.

Third, it questions the assumption that it is always appropriate to "engage men" in family planning discussions. At its best, family planning healthcare provides spaces for women on their own, where they are no longer under the male gaze, and can make choices that they feel is best for themselves. Supporting women's reproductive autonomy may mean choosing strategically not to engage men. If young women themselves can skillfully navigate the challenges of a gender structure that is stacked against them, the least we can do as practitioners and researchers is follow their lead.

Reproductive coercion does not maintain the strong statistical relationship to family planning, and we suggest this could be for a number of reasons. It is plausible some women who experience reproductive control from either partner's or extended families may not want to covertly use family planning. In a situation where women are reproductively controlled but not exposed to IPV, they may have a true desire to bear additional children – for emotional reasons, to secure more resources in the household, or to meet gendered

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expectations of what it means to be a “real woman”. For any of these reasons, it is not too surprising that reproductive control and family planning have a less clear-cut association.

There are however a number of limitations of this analysis. It would be valuable to know more about the total number of households approached since those willing to take part may be distinct from those households who chose not to participate (with potentially more violence among the non-responsive households). Some measures in the analyses show large associations, but these are not significant due to sample size limitations. The use of backwards elimination in the logistic regression has limitations, future research requires theoretically-driven models that are registered *a priori* – in other words develop a theoretical reason for including variables in a model and keep these in, regardless of p values. Finally, the authors used only a lifetime measure of IPV, but there may be important parts of current exposure to IPV and current family planning a lifetime measure misses.

Notwithstanding these limitations, this paper offers valuable lessons for the field. It is among the first studies to have made a distinction between overt and covert use of contraception. The authors determine associations between family planning and young women’s experiences of violence, which is key for future programming in contexts where IPV is endemic. The work provides an important starting point and offers the possibility of family planning services as spaces to support young women’s health and well-being.

Author contributions

AG & AH conceptualised and contributed equally to the first draft of the commentary. They both approved the final version.

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Conflict of Interests

AG & AH declare they have no conflict of interests.

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