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Navigating family planning access during Covid-19: A qualitative study of young women's access to information, support and health services in peri-urban Nairobi

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ABSTRACT

The COVID-19 response has profoundly affected women's access to family planning services in Kenya. While prior studies have shown how the COVID-19 response created barriers to accessing family planning (FP) services, less is known about how the pandemic affected the normative influence that partners, peers, and health providers exert on women's FP choices. In this qualitative study, we interviewed 16 women (aged 18–25 years), 10 men in partnerships with women, and 14 people in women's social networks across 7 low-income wards in Nairobi, Kenya. Our findings suggest that COVID-19 response measures changed the contexts of normative influence on FP: financial insecurity, increased time at home with husbands or parents, and limited access to seek the support of health workers, friends, and other people in their social network affected how women negotiated FP access and use within their homes. Our study underscores the importance of ensuring FP is an essential service in a pandemic, and of developing health programs that change norms about FP to address the gendered burden of negotiating FP during COVID-19 and beyond.

1. Introduction

In Kenya, the contraceptive prevalence rate improved from 46% to 58% in the last decade (2000–2019) among married women and unmet need for family planning[1] (FP) declined to 18% (GOK, 2019). Despite these improvements, access to family planning services is largely unequal in Kenya (Fotso et al., 2013) with large wealth inequalities, including within urban areas (Matthews et al., 2010). Compared to high income areas, in Nairobi's low-income areas for instance, fertility rates and unintended pregnancies are higher, and the contraceptive prevalence rate is lower (approximately 45% vs. 50%) (Fotso et al., 2013). The COVID-19 pandemic has deepened some of these pre-existing inequities and women have been disproportionately affected by the impact of COVID-19: more women (38%) than men (33%) reported complete loss of income/employment and women were more likely to forgo meals (71% of women versus 64% of men), and twice as likely to forgo essential health services (11% versus 5% of men), including family planning services (Population Council, 2020).

Measures for curbing the spread of COVID-19 applied by the Kenya government included lockdowns, school closures, mandatory quarantines, and dusk to dawn curfews. Access to those services deemed non-essential by the Kenyan government, such as SRH services, has been severely disrupted (FHI360, 2020; Kumar, 2020). Both men and women reported that fear of contracting COVID-19 at healthcare facilities, movement restrictions, and financial insecurity caused by lockdowns were major obstacles to seeking health advice and support during the pandemic (Gichuna et al., 2020; PMA Agile/Gender & ICRHK 2020).

While the financial and structural obstacles that women are facing during COVID are increasingly well documented (Wafula and Obare, 2014), less is known about how COVID-19 response measures affected the normative influence that partners, peers, and health providers have on women's family planning choices. Prior research has shown that social

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[1] In this study, we chose to use the term "family planning" in interview guides and throughout this paper because the study population understood "family planning" as referring to contraceptive methods.

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norms (and the anticipated opinion of important others) can have a strong influence on women's contraceptive choices (Wegs et al., 2016; Simkhada et al., 2010). In Kenya, these "important others", also referred to as key influencers are often partners, mothers, peers, and religious and community leaders (Wegs et al., 2016): their normative influence takes place in a context of unequal gender roles with unbalanced decision-making power which tend to disadvantage women (Kenny et al., 2021).

Our study aimed to uncover how COVID-19 response measures changed the normative context of FP and how women's influencers shaped FP decision making during the COVID-19 pandemic. We explore the roles husbands, partners, sponsors, parents, and friends play in shaping family planning decision making and access, particularly in contexts of financial insecurity and limited privacy exacerbated by the pandemic. Finally, for women who sought FP during the pandemic, we explore the changing role of health worker as key influencers and women's considerations of how disruptions to SRH services caused by COVID-19 affects travel, time, affordability, and FP method choice.

In line with prior research on how people influence each other's FP practices, we operationalize social norms theory as an analytical framework (Kane et al., 2016; Cislaghi & Shakya, 2018). Social norms are unspoken rules of acceptable actions shared amongst people in each group or society (Legros and Cislaghi 2019). The basic premise of social norms theory is that one's actions are influenced by one's beliefs about: (1) what others in one's group do (descriptive norms), and (2) what others in one's group approve and disapprove of. Social norms do not exist in a vacuum (Cislaghi & Heise, 2019) but are subject to the social influence of key reference groups and influencers (Mackie & Moneti, 2014).

2. Methods

2.1. Data and design

We designed a qualitative, formative study and conducted a total of 40 interviews with women aged 18–25 years, men, and other community members living in these wards who had previously consented to being contacted for research by Busara Centre for Behavioral Economics (Busara). All data were collected via phone interviews in two stages. First, women aged 18–25 years were contacted to ascertain their eligibility to participate in the study and to introduce the study. Eligibility was based on age, ward of residence, and being in possession of a 'safe device' (a mobile phone that could not be accessed by a partner or household member). During the interviews, women were asked about their partners and other people in their social network (hereafter referred to as key influencers (KI) to refer to women's ties with partners, family members, friends, and providers) who they would talk to about family planning. We asked women for the age, level of education and occupation of their partners and KIs. Based on this information, a purposive sample of men and other KIs from the panel was selected with similar demographic characteristics and invited to participate. We did not contact any one from women's own social networks due to safety and privacy considerations, particularly during COVID-19.

This study was the first phase of a larger mixed methods study which aims to design an online digital media intervention to change social norms about the acceptability of FP use among women 18–25 years and test the delivery modalities of this intervention. The larger qualitative study was designed to understand: (1) The social norms and sanctions of access and use of FP, (2) who women trust and consult while making FP decisions, (3) how women receive information about FP, and (4) women's social media use and the effects of COVID-19. In this paper, we present findings related to COVID-19 and FP. Participants were asked about how life has changed since COVID-19 including: (1) the challenges women faced accessing FP during COVID-19 - including for women living with their parents and partners, (2) changes to women's privacy and social media use, and (3) how COVID-19 has changed women's decisions and choices about family planning methods. Participants were asked to reflect on their own experiences or the experiences of other women.

2.2. Study sites and participants

This study was conducted in seven low-income wards in peri -urban Nairobi (Karangware, Kabiro, Gatina, Sarang'ombe, Laini Saba, Makina, and Kangemi). These wards are part of informal settlements with lack of durable housing, and limited access to adequate clean water, sanitation, and health services (Tusting et al., 2019). An estimated 70–80% of the total population of Nairobi live in similar informal settings (UN-Habitat, 2019) and experience the worst physical and mental health outcomes in Kenya (APHRC, 2014). Women living in Nairobi's informal settlements also experience higher rates of violence, unemployment, and poverty than women living outside informal settlements (Winter et al., 2020). We purposively selected seven low-income wards from this panel with a health clinic or family planning clinic in the ward that was operational during the time of data collection to provide referrals to health and FP services.

Participants were selected from a panel created by Busara in 2014 that included 33,829 women and 32,578 men living in 33 wards in Nairobi at the time of data collection in November 2020 who had previously consented to be contacted for research. Given that COVID-19 restrictions were in place and face to face interviews were not possible, we had to conduct phone interviews and sampled participants who were familiar with our research partner in wards where we could offer referrals to health services that were functioning during the pandemic.

Most participants were married and living together (25/40) and had children (28/40), had some secondary education or higher (32/40). 11 participants were employed, 1 was a student, 1 was a homemaker, 12 were doing casual jobs (e.g., manual labour), 15 were unemployed, 5 of whom lost their job due to COVID-19. All 16 women who participated were aged 20–25 years (median age = 23 years). Half the women were married (8) and living with their partners, and the other half were single. Most women we interviewed (10/16) were currently using family planning. Except for one woman who was pregnant, all married women were using family planning. Just over half (9/16) of women who were interviewed had between one and two children. Nine women reported being unemployed, two women were employed, one was a student, three worked casual jobs and one was a homemaker. The men who were interviewed were between 23 and 32 years old (median age = 27.5 years), partnered, and most (7/10) were married and living with their partners. Just over half the men interviewed (6/10) had one or two children. Key influencers were aged 23–52 years (median age = 32 years), where 10 were women and 4 were male (n = 14). Most (11/14) were married, and, except for one participant, all had between one and four children.

2.3. Data collection

We developed a semi-structured interview guide for data collection which included three sections: a vignette to explore social norms and attitudes of FP and identify people in women's social networks who supported and opposed FP; women's digital media use, where and how women access and share information on FP, and how COVID-19 affected women's privacy, relationships and access to and use of FP. Interviewers used one field guide for all interviews, where one section had additional questions for women to explore further in-depth conversations with key informants on FP.

Prior to data collection, interviewers completed a three-day training for this study which was led by CO and AS. The study team tested and revised the interview guide through practice interviews and by discussing the meaning and interpretation of each question. The interview guide was then piloted with 10 participants from the panel described above, and further edits were made. Data collection was phone-based and took place in November 2020 during the COVID-19 pandemic. CO,AS

and KG, managed, and led the data collection process. All data collection was conducted by four trained researchers who had prior experience conducting qualitative interviews in English and Swahili. Interviews were conducted over the phone in Swahili and lasted 50–80 min.

Researchers telephoned participants who met the inclusion criteria to share information about the study, assess eligibility and schedule a convenient time for the phone interview. More information about the study was shared via WhatsApp with participants and discussed on the phone. Consent was sought prior to the interview and audio recorded: first we sought permission to audio record and researchers then read out the consent scripts. Recognizing that consent is iterative, and participants might be overheard in their homes, we built in the following safeguards during the interview: a safe word which participants could use to indicate their conversation was no longer private, check-ins for privacy and comfort with continuing the interview, and the use of vignettes to discuss sensitive topics. All participants received phone credit and a list of local resources and health facilities, which were operational at the time of data collection, where they could seek health services, including more information about family planning.

The study team had daily phone debriefs to discuss data collection, the safety and comfort of participants, and emerging themes. After interviews were completed, the research manager checked whether consent was sought and reviewed audio recordings. A researcher who had not conducted the interview translated and transcribed the interview and the senior researchers in the team checked a random selection of transcripts were for quality and compared to audio recordings. All data were stored securely on password protected computers.

2.4. Analysis

We conducted a thematic analysis. AZ developed an initial codebook based on the interview guide. All co-authors then reviewed two transcripts and revised the codebook, AZ, AS and KG then reviewed additional transcripts using the revised codebook and then coded all the transcripts iteratively adding new nodes and discussing changes every day during coding. The aim of this analysis was to explore the implications of COVID-19 on FP decisions, access and use with a focus on the changing dynamics between women and the key influencers who shape women's FP decisions. RH and AB conducted further analyses of all the nodes related to how COVID-19 had changed which included: employment and finances, income spent on FP, access to FP planning, mobility and privacy for women, decision making for FP, household dynamics, and social media use. RH and AB had frequent meetings to discuss emerging themes and defined the following additional themes: financial stress and difficult financial choices, negotiating access to FP, privacy, secrecy and changing household dynamics, disruptions in access to FP, changes to FP methods and providers. Findings from each round of analysis were discussed with the researchers who conducted the interviews and all the co-authors.

2.5. Ethical approval

This study received approval from the ethics committees in Strathmore University, Nairobi (ref SU-IERC0898/20) and the London School of Hygiene and Tropical Medicine (ref 22480).

3. Results

We identified three interconnected ways in which the COVID-19 response in Nairobi affected the normative influence of partners, parents, friends and health workers on FP decision making and women's access to FP services. First, financial insecurity impacted the priority that women and key influencers placed on FP methods and women's financial dependence on partners or parents. Second, lockdown measures and restrictions to movement changed household dynamics and women's social networks reducing privacy and access to support from friends. Finally, structural disruptions at the health systems level reduced contact with health providers and changed access to and affordability of contraceptives. Several participants agreed that together these factors would increase the number of pregnancies during COVID-19, naming pregnancies during this period "*corona babies*" (KI_35_F).

3.1. *"There is no money at home": the role of husbands and parents in FP decisions in contexts of financial stress*

Many women identified their mothers and partners as key influencers of their decisions about FP use: mothers were important sources of information about their own experiences with FP, while discussing FP use with husbands was key to plan family size together and avoid possible conflicts. The first theme relates to the normative influence of parents and partners within the context of the financial insecurity generated by the pandemic, and how women negotiated with key influencers to access FP.

Most participants reported financial stress and reduced household income during the COVID-19 pandemic, due to job losses or salary reductions. One woman, for instance, said: "*I'm breastfeeding, and we have no money, my kids go hungry as my husband was unable to secure work on this particular day. It's so stressing"* (KI_33_F). The uncertainty and stress linked to reduced incomes further presented difficulties in decisions about allocating funds to rent, food, airtime/mobile data ("bundles"), or family planning. Two women respectively said: "*You cannot split the money for food with family planning because it will not be enough"* (W_4) and "*many people have lost their jobs. So, would you look for money to go see a gynecologist, or would it be for family's food?*" (KI_36_F). Several women expressed that an implication of this scarcity, for women who wanted to use FP but could not afford to, was pregnancy. According to a male participant: *"for those who were not using [FP], they have been forced to use [FP] until the end of COVID to reduce budget of other kids because there is no money"* (KI_34_M). As this example suggests, financial insecurity also affected the type of method used.

Similarly, one man said: "*there is no money and maybe [women] cannot afford those pills so [that] means you look for an alternative way which is not expensive*" (P_18). In line with this, one woman explained how they were "f*orced to go for the cheap methods"* (KI_29_F). Although a few participants did not link reduced household finances to the challenge of purchasing contraceptive methods during the pandemic: they explained that: "*family planning is free*" (KI_38_F) and *"many hospitals are giving the methods free*" (W_12). However, even they acknowledged the challenges of bearing the associated costs, both the usual costs (e.g., transport to clinics) and the new covid related ones (e.g., the cost of a face mask) which were a prerequisite to enter a hospital and get contraceptives: *"When we go to any healthcare facilitates, you must wear a mask …. COVID*-19 has *really affected us in the sense that my friends do not even have those 20 shillings to buy a mask. (W_1)"*. These additional costs associated with the COVID-19 measures were found to further strain household budgets, mediating and limiting access to health centers, and to FP, for women.

Within this context of limited financial resources, both women and men described how COVID-19 increased women's financial dependence on their husbands: "*there are few things women can afford on their own for themselves. They do not have to ask from the men - things like sanitary pads. But now they are forced to ask from the men. Which is a challenge.*" (KI_27_F). A man agreed and said: "*The husband cannot give you money to go buy the pills yet there is no other money."* (P_19). The reluctance to purchase FP in times of financial stress was also related to a lack for support for FP use, particularly among partners: one male participant said *"you will need to agree with the husband if you will use FP or no*t" (P_18) and another explained: "*It is hard to convince the husband, you may find a woman wants to use FP, but a husband doesn't*" (KI_40_M). We found that spousal consent and support were critical.

One woman further suggested that conflicts around the use of family planning and its cost might evolve into further tensions: "*The husband doesn't want to financially support the wife to be able to buy family planning.*

This means that the wife will not be sexually involved with the husband and that will create conflicts in the house" (W_3). Several other participants also described the challenges of negotiating with husbands in the context of additional financial insecurity and dependance the pandemic created. Importantly, discussions on the cost of family planning weren't limited to households of married women. Women living with their parents also discussed the implications of financial dependence on parents during COVID-19: "*Right now, my parents are still working but I can't just ask my mum to buy for me stuff … because they also have their own needs and also, they are getting paid half of the salary they used to get before COVID-19.*" (W_6). COVID-19 strengthened the normative influence, and gatekeeping role husbands and parents played in women's access to FP.

However, several participants described how women found alternative avenues of income generation, such as through "sponsors", where men give women goods or money in exchange for sex. Two men described sponsorship as a response to women "*lack[ing] her personal things"* (KI_34_M), underscoring the implications of financial dependence COVID-19 is engendered. Reflecting on the desire to alleviate her parents from the financial burden of supporting her, a woman for instance said that a girl might, "*See [that] her parents have no money and [that] there is a young man who can provide for her money. So she thinks the only way she can get money out of the young man is via satisfying him, and that means sex*" (W_12). Participants suggested there was an increase in sponsorship during COVID-19 as a source of income due to financial stress or job loss: "*Covid has caused a lot of stuff to go wrong. People have bills to pay like the rent, food, electricity, and water but there is no money. The young ladies are forced to find themselves sponsors to support them*" (W_6). Sponsors we found were an alternative source of income for some of the women in the informal settlements.

These relationships however, had the effect of increasing the risk of unwanted pregnancies, which was further exacerbated by the limited access to FP: "*Currently [access to family planning methods] are unstable … [Women] are using the family planning method to avoid getting pregnant since most of them were sleeping with different men to earn for a living*" (W_11). Our findings thus show that this financial insecurity and increased dependance on husbands and parents increased their normative influence on women's FP choices, and increased the use of sponsorship to access resources and counteract the financial dependencies women faced within their households.

3.2. *"Their husbands are present at home each time": Changes in intimacy, privacy, and peer networks*

This second theme relates to the ways in which the COVID-19 response, lockdown measures, increased the time women spent with their household members, decreased women's privacy to seek and use FP, and limited women's access to friends and social support.

Several participants described how being at home increased frequency of sexual intercourse, and, in some cases, increased a desire for FP. One woman she said: "*Right now I am idle and have a lot of time with my partner, so I have to be very keen on family planning unlike the time I was working, and we had less [time] together"* (W_7). And another: "*Men currently want to spend more time with their wives. You find that even when a man comes home from work, they want to find their partners at home all the time and what he needs most is sex and that will happen without protection*" (W_6). Other participants also indicated that there were many pregnancies during the COVID-19 period: "*Many women are now pregnant because their husbands are present at home each time*" (KI_34_M). Gender based violence (GBV) was also reported and linked to the financial stress brought by COVID-19 and increased time at home. One woman (KI_36_F) explained: "*There is more GBV as people spend a lot of time [together]. There is increased unemployment and poverty. Some [husbands] tend to take off their steam through violence [on women*]" (KI_36_F). Others also cited that financial stress and instability lead to an increase in GBV, "*generally, they face challenges like mistreatment by the husband, lack of money to even buy food for the family and pay rent*" (KI_29_F) and "*finance can be a challenge to them when it comes to accessing family planning and domestic conflicts*." (P_23). The nature of negotiating and using FP for some women was thus linked to violence, or threats of violence at home.

Husbands being at home all the time also affected women's mobility and privacy. A woman suggested that during COVID-19: "*You may find that the husband does not want the wife to leave the house or if she does, she is given limited time to come back. That makes it hard for the wife to visit the health centers for family planning. So, some of them end up getting pregnant*" (W_9). Other women who reported difficulties in visiting health centers also alluded to a lack of privacy in seeking FP services or using their FP method of choice at home during the pandemic.

Women who lived with their parents also reported the challenge of limited privacy. One respondent explained: "*They are afraid of going to access family planning services because the parents will know*" (KI_31_M). Several other respondents expressed how reduced privacy at home made it harder to use FP in secret during COVID-19. One man explained that women now had "*no time to take the medicine because they probably used to do it in secrecy, but now the parents are always there. They might also miss hospital appointments because there are other duties given by parents*" (P_25). In most cases parents were said to be unsupportive of family planning and one female participant explained how it was hard to "*talk freely*" (W_13) in the presence of parents. One participant, for instance, described how young women living with their parents "*may also be afraid to open up to their mothers about their use of family planning making it hard for them to ask for permission to go out and get the family planning*" (KI_27_F) or to talk to their mothers about any side effects if they were using FP secretly.

Unlike partners or parents, nearly all women identified friends as key influencers for finding trusted information on FP and making decisions about FP use and described their friends as people they could discuss FP with, confide in and who would not mislead them with advice or poor information. However, participants reported more limited opportunities for women to seek support in their social networks during COVID-19. The pandemic disrupted peer support dynamics that helped women discuss and access FP. As one woman explained, "*there is no way one can interact with people and discuss family planning due to the COVID-19 measures*" (W_13). Participants gave several examples of the fact that women could see friends less. One, for instance, said: "*I stopped hanging out with friends, sharing new ideas and socializing at school due to the no overcrowding restriction put in place*" (W_3). And one man agreed: "*Women are mostly indoors during this Covid period. They rarely get to interact with other people like they used to hence have no one to share their issues with*" (P_23). The challenges in reaching friends and social networks women described were compounded by limited resources to engage with friends online and on social media. While participants who could afford phone credit did not have any change in their use of social media, many noted that financial stress resulted in fewer people in their social networks being available online to talk: "*There is no money to buy bundles. Some people have sold their phones to get money to cater for other needs"* (P_23). As one participant described, this influenced contact with friends: "*Because use of social media requires bundles, and I don't have the money to buy airtime so I can go for weeks without connecting with people. [My social media use] has changed because I don't have the time to access the internet and money is a challenge."* (KI_29_F). Even though online interaction was mentioned as a way to connect during COVID-19 restrictions, for many participants this was not the case and online contact with their networks and friends, who were more likely to support decisions to access to FP, was negatively affected.

3.3. *"The doctors may not want to touch you": Changes in access to health providers*

Our final theme relates to the changes in the access women had to health care providers who were identified by most women as key influencers in their FP decisions, especially since most women reported seeking FP from public facilities, private clinics, and pharmacies/chemists. The difficulties experienced in accessing health services affected women's ability to connect with providers about their decision to access

FP.

Participants underscored that "*many women cannot go to hospital because of Covid-19*" (K_32). Reasons for this ranged from restrictions imposed by health facilities on the number of patients and a fear of contracting COVID-19: *"women are afraid of contracting COVID-19 or that they have to get tested for COVID-19 if they go"* (KI_39_M). In particular, government hospitals were affected, and one woman described the following challenges:

> "It has been a challenge especially to the people who access family planning from the county government hospitals. Challenges when it comes to social distancing, health care workers not operating, someone can forget to put on masks when visiting the clinic and the health care worker refuses to attend to them and by the time, they return for the family planning service, they find that the method is no longer available at the facility." (KI_27_F).

When women were able to reach a health center, they faced longer waiting times – resulting in delays to access, start or continue FP – or very limited time or attention from providers: "I*t is even difficult to talk to doctors as people fear COVID-19*" (KI_36_F), or as another participant highlighted: "*If you go there, you will not be served the same way you used to be served, you are served in a hurry and that is it. Additionally, you may go [to the clinic] and things are working in slow motion. If you go to queue for a family planning injection at 7 a.m. you end up leaving at 1 p.m. and it is just an injection you have gone for. It is just a process-things are hard because of Covid"* (W_1). Another way in which women's access to providers was disrupted was because some facilities conducted most of the consultations via text message instead of in-person. One man described the limitations of this change: *"[Women] are told, messages will be sent through phones for them to read for themselves. When the messages are sent, they can't understand because they are illiterate. Face to face discussion is better [so] they can ask any question" (KI_34_M)*. While health centers implemented a digital method of reaching women to increase access to information, participants underscored the limits and inaccessibility of using text messages for FP information and discussion with clinicians, indicating the importance of these in-person conversations with providers.

Some participants cited that the health providers opted to offer methods that required less contact with the patients for fear of spreading COVID-19: "*One may want implants but because of COVID-19, [but] the doctors may not want to touch you, so they end up settling for injections*" (KI_36_F). Several participants described how women had to change their FP method due to shortages in FP methods, or limited access to providers: "*It has changed decisions as, for instance, I won't go and get the family planning method of my preference, I use the available ones due to Covid-19*" (KI_36_F). For example, one participant described replacing her coil: "*When I wanted to replace my coil after [its] expiry, I had to visit the facility more than 5 times because the doctors were either not available or the family planning methods-the coil - wasn't available"* (KI_29_F). The shortages of FP methods in health facilities meant that those who could not afford alternative methods would have to choose which alternative method was available or fail to access FP at all. Another participant explained: "*sometimes when they visit the hospitals for family planning, they would be told that it is not possible to get the injection services so they would give them some pills to use until covid is over. A friend of mine told me that happened to her"* (W_8). However, one participant also discussed challenges with accessing the pill: "*Some government hospitals do not have them so one has to spend money to buy them*" (KI_37_F). Another participant commented specifically on the implant: "*Right now, the doctor cannot remove the implant family planning because they cannot touch you because of covid. They cannot even put implants on you*" (KI_38_F). This participant also expressed concerns with the injection: "*The only family planning method they are administering currently is injections only. With injections, it is tricky because if you forget to get the injection in a day or two and you had unprotected sex, you can get pregnant. You find this challenging because with covid, everyone is busy and not everyone has the time to go to the doctor every three months. Implants ended with the pandemic, they cannot remove it because of covid"* (KI_38_F). The difficulties reported around accessing the pill, injections and implants reflect the difficult experiences of women who sought to use FP during COVID-19 and limited choice women had once they reached health facilities. We found that the changes to the quality of care from providers reduced women's options for FP methods and affected whether they could continue with their preferred FP method.

With the pressure on public health facilities during COVID-19 and the challenges described in accessing these services, we found that women sought FP from alternative providers like pharmacies and private clinics because "*health facilities are busy with covid 19*" (KI_33_F). However, acquiring FP from a different location also had cost implications as FP is not free from the chemist or from private facilities. In addition, a few women also expressed concern about the quality of FP from chemists: "*You find that the chemist people can replace [family planning methods] with non-legit ones when they get exhausted and pretend that it is a new product in the market which is much better than the normal one. That can lead to young women getting unwanted pregnancies - like currently people are getting pregnant even after using the family planning*" (W_6). The additional cost of purchasing FP and the fear of the quality of the method complicated the FP decision for women who sought to use FP.

4. Discussion

This qualitative study drew on 40 interviews with women and people they discussed FP within 7 low-income wards in Nairobi. We explored how COVID-19 response measures affected women's access, decision, and choices about family planning. We found that COVID-19 generated financial insecurity, changed household dynamics, and reduced women's financial independence, mobility, and privacy. These changes affected the normative influence that partners, peers and health providers exert on women's FP choices: strengthening the influence of partners and parents who often limited access to FP, and weakening the influence of friends and health care providers who were reported to be more supportive about using FP. The reduced avenues for interaction with friends and health providers affected access to trusted information which women found useful for their FP decisions. Health systems challenges, shortages of methods and the financial strain associated with purchasing methods in private chemists compounded the changes to normative influence we document, and increased women's dependence on partners and parents. Several women reported a fear of unplanned pregnancies, which other studies have linked to the closure of schools and increased reported sexual activity among this age group (Hakansson, 2020). Evidence from other studies conducted in high-, middle- and low-income countries during COVID-19 link social distancing and self-isolation to discontinuation of FP use, and increased reports of unplanned pregnancies (Caruso et al., 2020; Suresh Vora et al., 2020). Our findings affirm the importance of social and gender norms in shaping FP choices which is also seen in the literature, such as in Cislaghi and Shakya (2018) who find that social norms can help explain reproductive health decisions including the use of modern family planning. We also show how this normative influence can shift during times of crisis and uncertainty.

Job losses and worsened financial situations at the household level meant that household needs were prioritized over FP: both women who would previously access FP or wanted to start using FP, struggled to, or were unable to, meet this need. Recent reports on the unmet need of family planning in developing countries suggest that 214 million women of reproductive age who may want to avoid pregnancy are not using any modern contraceptive method (Sedgh, 2011). These figures have been linked to the low economic status of households in these regions. Even prior to COVID-19, a large body of literature linked poverty and a loss of income to lower FP access (Ezeh et al., 2010; Tetui et al., 2021) and our findings suggest that COVID-19 may entrench and exacerbate financial barriers to FP, leaving it to women and their families to choose between FP, rent, food, or airtime, and increasing the possibility of sponsorship (Gichuna et al., 2020).

In Kenya, other studies have found that poverty and inequitable gender norms assign women and girls household responsibilities and constrain women's choices for reproductive health needs (Steinhaus et al., 2016). In line with prior studies, we also find that gender norms and interpersonal dynamics between women and their key influencers were critical for FP practices and decisions (Wegs et al., 2016). Other studies, including in Kenya, also identify husbands, parents, and friends as key influencers in shaping women's FP practices (Kenny et al., 2021). We found partners and parents would gatekeep and limit FP choices. Married women in Tanzania mentioned their husband's opinion and or approval as a key consideration in their FP decision (Mosha et al., 2013) and another study in Ghana found husbands shaped their wife's decisions because of their decision-making power at the household level coupled with patriarchal orientations that see men as the breadwinners (Fuseini, 2019). A study on child marriage and planning also found that men were considered formidable barriers to women's decision-making about fertility, contraceptive use and health care utilization (Greene and Ellen, 2019). Regarding the role of parents and friends in shaping FP choices, other studies also find that parents are apprehensive about their daughters' access to family planning (Akers et al., 2010). and friends can influence both the type of FP information women have and may influence women's contraceptive decisions (Madden and Secura, 2013). Importantly, the influence of these social networks is not static (Cislaghi and Hesse, 2019): we found that COVID-19 lockdown measures and pandemic related financial insecurity affected the normative influence on women's agency and decision making related to FP.

Our findings about the normative influence of health care providers are in line with existing evidence that suggests the first discussion with a health care provider is a key determinant for uptake of contraceptive methods among women of reproductive age (Melka et al., 2015). Health care providers play a key role in providing information on FP, including the side effects of modern FP (Chebet et al., 2015). However, biases held by health care providers can also affect women's right to choose the preferred FP method, creating disparities in access to contraception for women with the highest unmet need, like those living in poverty (Habtamu, 2019). Although prior studies demonstrate how the norms and attitudes about FP health workers hold can serve as a barrier to access for women, the women in this study mostly described the challenges of being able to see or talk to a provider during COVID-19 as a barrier to accessing FP, and how healthcare providers suggested FP methods that would not entail physical contact to avoid the spread of COVID-19.

In addition to changing the normative influences on women's decision making, COVID-19 also restricted sources of FP information for women since they were disconnected from their social networks, health centers were challenging to access and any school-based education on reproductive health was discontinued. Women who had access to the internet were constrained by lack of internet data as other household needs were prioritized. This digital inequality in low-income countries has been linked to poor socioeconomic outcomes (World Bank, 2016). Specifically, the barriers to digital access have been found to be worse for women, negatively impacting their access to information and opportunities (Kuroda et al., 2019). COVID-19 response measures therefore also disrupted avenues of social support and information that usually provide young women with an opportunity to hear potentially positive information on FP use, even though these avenues can also perpetuate myths and misconceptions on FP (Burke et al., 2011).

Finally, our findings also uncover the implications of the health system's response to COVID-19 on FP access and method choice, and how structural changes within the health system intersect with normative influence. Like other studies (Kumar, 2020; FHI 360, 2020), we find that COVID-19 overburdened health systems and disrupted access to FP. As a study regarding the impact of COVID-19 in Kenya, Uganda, and Tanzania points out, there was already a shortage of healthcare professionals and overloaded health care facilities prior to the COVID-19 pandemic (Pallangyo, 2020). Like our findings, prior research also shows that disruptions to FP particularly affect women who rely on government health facilities for FP, where they can access FP methods for free, further entrenching pre-existing inequalities (Machiyama, 2018). Evidence suggests that even where the facilities exist and women can access a provider, there have been reports of shortages in FP methods: a study examining the impact of COVID-19 on healthcare access for female sex workers residing in low-income areas in Nairobi found that these young women experienced challenges in accessing family planning options due to shortages of FP methods and finances (Gichuna et al., 2020). In India, the largest producer and exporter of FP methods reported commodity and supply shortages after the largest condoms manufacturer in Malaysia closed down (Pratt & Frost, 2020; Gangulay et al., 2020).

Our study found that young women reported challenges of accessing their preferred FP method at public facilities, thereby opting to buy FP from private clinics and commercial drug sellers. Those who could not access or afford to purchase their preferred methods had to switch methods to what was available. A survey of 1357 adolescents and youths aged 15–24 years in 2019 in Nairobi also found that young people in most cases got their primary contraceptive methods from pharmacies (35.7%) (PMA Agile/Gender & ICRHK 2020). This is in line with our findings with women being forced to access FP elsewhere during the COVID-19 period. Radovich et al. (2018) observe that these private sources are characterized by faster and more discreet services as well as accessible locations, extended opening hours and confidentiality which may be more attractive to young women than the public clinics. However, our findings also suggest that women have concerns about the quality and affordability of accessing FP through pharmacies, and that during pandemic this option was not available to many young women who could no longer afford to purchase FP methods. WHO (2020) reports indicate that limited access to contraception during the COVID-19 period has resulted in an increase in the incidences of unsafe abortions in developing countries.

This study has several limitations. First, although our work provides insights into FP access among the sample of women included who live in low-income neighbourhoods during COVID-19 in Nairobi and who could participate in a phone interview, its qualitative findings were not designed to be generalized. Interviews were conducted over the phone to prevent the spread of COVID-19 and given the sensitivity of the topic; it is possible that participants may have been more reluctant to share information they may have shared in a face-to-face interview. However, it is also possible we were able to reach participants who may not have been able to travel to a face-to-face interview. Our study was also conducted at one time point and the findings we present in this paper were drawn from a subset of the overall interview guide of which COVID-19 was only one section: this reduced the time to ask to follow up questions and questions focused on asking participants to share what changed due to COVID-19 and not reflect on their lives prior to COVID-19. Although we explore the different experiences women who were living with partners or parents had, we could not draw out differences between the experiences of married and single women during the pandemic and this is an important area for future research.

However, our findings also have several key implications. First, our results highlight the gendered burden that women face in negotiating FP in their households. The significance of key influencers and social networks in women's FP decisions demonstrates the role of social norms and gender dynamics in determining FP access. SRH programs should commit to engaging with social and gender norms that shape FP access and better understand the influence of partners, family, and friends, including how this influence changes in times of crisis, stress and uncertainty. There is a need to further consider the role of programs and interventions in changing social norms held by partners and parents and explore opportunities for peer-to-peer interventions. Online spaces and social media remain largely unexplored, but present avenues for women to access FP information. Secondly, given the interpersonal, financial, and structural challenges that women face in negotiating access to FP, FP should be considered an essential service in health care facilities.

Government health facilities, non-profits, and other SRH actors and

funders should commit to enhancing the efficiency of FP delivery systems in the context of COVID-19, or other pandemics, to prevent interruption in the delivery and mitigate the cost implications. This will be important to ensure that the gains made in enhancing sexual reproductive health are not reversed. Future research should examine how COVID-19 has exacerbated inequalities in access to FP, better understand the role and reliance on commercial FP providers, explore the burden of unmet need of FP brought about by financial stress and uncertainty caused by COVID-19, and explore the changes to social and gender norms related to FP decision making. Additionally, research should continue to center the experiences of women and build in adequate safeguards if conducted remotely.

Ethical statement

This study received approval from the ethics committees in Strathmore University, Nairobi (ref SU-IERC0898/20) and the London School of Hygiene and Tropical Medicine (ref 22480).

Declaration of competing interest

All authors declare no conflict of interest.

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