



My husband will love me more if I give birth to more children: Rural women's perceptions and beliefs on family planning services utilization in a low resource setting

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ABSTRACT

Introduction: Responsibility for family planning in low resource settings is almost solely delegated to women, with very low male involvement. This study investigated rural Tanzanian women's perceptions and cultural beliefs of the barriers to family planning services utilization.

Methods: This study used a qualitative descriptive approach drawing on four group discussions with 20 purposively selected married women with two or more children. The study followed COREQ guidelines for reporting qualitative studies. Data were collected from participants at four health facilities in Bagamoyo and Kisarawe districts in Pwani, Tanzania.

Results: Participants' occupations included housewives, small-scale farmers, and entrepreneurs. Most women were Muslim and had a primary school education.

Five main themes were identified: use of modern and traditional family planning methods; my husband will love me more if I give birth to more children; men's expected roles in family planning; provide education to dispel myths; and religious barriers. Associated sub-themes covered use of strings, snares and pigis; calendars; breastfeeding linked to family planning; men as heroes for having many children; men not having time to attend clinic; and conflicting sources of health information.

Conclusion: Lack of adequate family planning information; beliefs on and use of traditional/unconventional methods; gender roles expectations that influence decision making and limit women's choices of family planning methods and; socio-cultural and religious beliefs were main perceived barriers for family planning utilization in this study. Mitigation of these barriers depends on the sustained engagement of key stakeholders including religious and community leaders. Health education must be designed to adapt socio-cultural and religious doctrines with benefits of family planning and health outcomes. Health delivery services must also address women's' prevailing perceptions and beliefs with emphasize on the partner communication and their encouragement of men's' involvement in reproductive health services utilization.

1. Introduction

Adherence to family planning is an essential component of reproductive healthcare which could be utilized by both women and men to prevent unintended pregnancies, ensure optimum spacing of children and, avoid adverse health and socioeconomic consequences (WHO, 2018). The uptake of reliable family planning methods has the potential

for averting about 32% of all maternal deaths and almost 10% of child deaths in countries where mortality rates are high (Cleland et al., 2006). Despite these, family planning utilization has remained persistently low in sub-Saharan Africa (Ajayi, Adeniyi, & Akpan, 2018; Blackstone, Nwaozuru, & Iwelunmor, 2017; National Bureau of Statistics (NBS), 2016) and is conventionally viewed as a woman's responsibility even though men predominantly make decision about all family matters

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including use and choice of contraception for women (Kassa, Abajobir, & Gedefaw, 2014). The preference for using traditional (e.g. abstinence, withdrawal) and unconventional (e.g. use of lime, traditional ring) over the modern family planning methods (intrauterine devices, oral contraceptives) is also common in this continent (Ajayi et al., 2018; Gebremedhin, Kebede, Gelagay, & Habitu, 2018). This poses the risk for unintended pregnancy and poor health outcomes of women, children and families.

Tanzania is among the sub-Saharan countries with high maternal mortality rates (556 in 100,000 live births) and neonatal deaths (25 in 1000 live births) (NBS, 2016). Low family planning services utilization in this country may be contributing to the maternal and neonatal morbidity and mortality. Only 56% of married women aged 15–49 years use family planning in Tanzania: of these women 6% use traditional methods (strings, snares, withdrawal), 13% use injectable methods (which are the most popular), 7% use implants, and the remainder oral or tubal ligation methods (National Bureau of Statistics (NBS), 2016). For males, condoms are the most common contraception method, with less than 1% having had a vasectomy (Frajzyngier et al., 2006). In 2016, more than one in five married women had an unmet need for family planning (22%), with the problem being greater in rural than urban areas (NBS, 2016). Long acting and permanent contraception methods are particularly underutilized (NBS, 2016).

The perceived reasons for low use of family planning methods in low-income countries include couples desire for many children, religious and traditional beliefs, myths and lack of correct information about contraceptives (Adongo et al., 2014; Apanga & Adam, 2015; Shattuck, Perry, Packer, & Quee, 2016). In Tanzania, low male involvement in modern family planning methods is a barrier for the overall success in reproductive health services, with this attributed to men's opposing roles of being the head of the house and needing to demonstrate virility (Kessy & Kayombo, 2015).

Women in various studies in low-income countries perceive that men contribute to low utilization of family planning and relate this to gender norms that prioritize the role of childbearing and child-rearing for women (Kabagenyi et al., 2014) and men's need to produce many children to signify virility and fulfil religious requirements (Adongo et al., 2014; Akpamu, Nwoke, Osifo, Igbinoia, & Adisa, 2010). Contrarily, women also report negative perceptions regarding male contraception and that they are unwilling for their partners to use these. For instance, women have been reported to believe that a vasectomy use could damage their partners' genitals and disrupt their sex life (Asare, Otupiri, Apenkwa, & Odotei-Adjjei, 2017). They also believe that vasectomy will not benefit new wives in cases of divorce or death of a former wife (Asare et al., 2017). However, some women indicate that they would support their partners undergoing a vasectomy if they both received health benefits and the financial burden on the family was reduced (Asare et al., 2017).

Men's involvement to family planning programs is recognized as a way to achieve optimal women's reproductive health outcomes (Lundgren, Cachan, & Jennings, 2012), improve couple communication, relationships, childcare (Shattuck et al., 2016) and reduce the contraceptive load for women (Lewin & Silverstein, 2016). The number of couples with differing fertility goals is decreasing in Pakistan, India, Malaysia, Thailand, and the Philippines (Mason & Smith, 2000), and men are increasingly realizing their roles in reproductive health (Inhorn & Patrizio, 2015). However, studies in low-income countries have reported less progress and recommend including men as equal partners and beneficiaries of family planning, and advocate for educating men continually about the benefits of contraceptives (Ajayi et al., 2018; Kabagenyi et al., 2014; Shattuck et al., 2016).

To date, women's perceptions and beliefs regarding barriers for utilization of family planning methods in Tanzania have not been investigated. Obtaining insight from women, who are the predominant users of family planning services in this country, will contribute to the ongoing efforts for improving maternal and child health outcomes.

2. Methods

2.1. Design

A descriptive qualitative design using focus group discussions (FGD) was employed to obtain a detailed description of women's perceptions and beliefs regarding family planning utilization. The choice of FGD enabled the generation of multiple views with shared and divergent ideas among women, which enabled gaining insight of their perceptions and beliefs (Silverman, 2004).

2.2. Study setting

This study was conducted in health centers and district hospitals in Bagamoyo and Kisarawe districts of Pwani, the coastal region (NBS-Tanzania, 2013). Pwani has a fast growing population, high fertility rate, and low use of family planning. The region had a population of 1,098,668 people in 2012, compared with 885,017 people in 2002; this represents a significant increase of 213,651 people (24.1%) over a decade (NBS, 2011, 2013). The average Pwani household size is 4.3 people. Tanzania is a low-income East African country with a population of around 44.9 million people; 31.3% of the population live in extreme poverty (NBS, 2016).

2.3. Participants' recruitment

The discussants were selected using purposive sampling, to obtain culturally-based descriptions of rural women's perceptions and beliefs about family planning options. After ethics approval had been granted, health facility and community leaders were informed about the study and helped in identifying potential village dwelling women recruits who met the inclusion criteria. The inclusion criteria were married women, who had two or more children, and voluntarily agreed to participate. The information of the potential participants was obtained at the health facility. Thereafter, the principal investigator traced women at their communities through community leaders. The recruitment was conducted by the principal investigator, who explained in detail about the study and agreed with the participants about the convenient day and time of the discussion.

2.4. FGD guide development

A FGD guide was used to explore women's perceptions and beliefs on family planning utilization. The guide was informed by a review of relevant literature, and the data analysis from a larger study that collected information from men and healthcare providers also under review. The FGD guide of the present study with women, covered demographic information, methods of contraception used/heard, traditional practices in prevention of pregnancies, benefits of family planning, perceived role of women in men's uptake for use of contraception, and perceived barriers to family planning services uptake in rural communities.

2.5. Data collection

All data collection and subsequent analyses followed COREQ guidelines for reporting qualitative studies (Tong, Sainsbury, & Craig, 2007). Four FGD with a total of 20 participants (each FGD included five women) were conducted between September 2017 to February 2018. All the FGD were conducted at the health facilities, which was agreed by participants as the most convenient venue for the discussions. The FGD were conducted in Kiswahili (national language), lasted for approximately 90 min, audio-recorded and was facilitated by the principal investigator, who was bilingual and experienced in FGD moderation (Dickson-Swift, James, Kippen, & Liamputtong, 2007). The moderator had no prior knowledge of the participants (Tong et al., 2007). All

women were encouraged to participate in the discussions to capture shared and diverse perceptions and beliefs of family planning services utilization (Krueger, 2014).

2.6. Ethics

Ethical approval was obtained from the Ethics Review Committee of the Aga Khan university with clearance certificate number Ref: 2017/238/jl. Permission to conduct this study was subsequently granted by the Bagamoyo and Kisarawe District Municipal Councils along with the relevant health facility management and village officers. Prior to discussion, the principal investigator explained orally and in writing about the study objectives and procedures, issues of confidentiality, the importance of voluntary participation, and the need for individual informed consent. Participants were assured that data would be kept with security codes and accessed by researchers only. Each participant was assigned a number that was used for their references instead of real names. All the participating women provided written informed consent for the participation and recording of the discussion.

2.7. Data analysis

All FGD were audiotaped and each audio-recording was transcribed in Kiswahili and then translated into English for analysis. A bilingual Kiswahili-English linguist assisted the researchers to review the translated versions against audio-recordings to check for clarity and consistency. QRS NVivo version 11 computer software was used to support analysis, and allow easy movement within the data (Flick, 2014). Two research team members (AM, EP) analyzed each FGD concurrently to ensure rigor, and then the identified themes across all FGD were combined and compared (Tong et al., 2007). To ensure credibility the unclear issues arising from initial analysis were clarified (probed) in the subsequent FGD with women. The research team (AM, EP, SB, EH) closely examined the selected data, performed coding, and constructed sub-themes based on data characteristics to uncover main themes pertinent to the phenomenon, following the framework described by Braun and Clarke (2012).

3. Results

Data were collected from the 20 participating women at four health facilities (two hospitals and two health centers) in Bagamoyo and Kisarawe districts (Table 1). Participants were from various tribes; the Ngendereko, Mha, Luguru, Zaramo, Makonde, Zigua and Matumbi. The women's occupations were housewives, small-scale farmers, and entrepreneurs. The small-scale farmers grew maize, vegetables, beans, and

groundnuts near their houses. Fifteen out of twenty participants were Muslim and most had a primary school education. The general household income was approximately 15,000–30,000 Tshs per month (7–13 USD). The number of children ranged from two to six children per woman. Four women from Bagamoyo and two from Masaki attended the FGD with their children. Among these, one woman from Bagamoyo had twins, and one from Masaki had two children (an infant aged 6 months and a toddler).

Five main themes were identified from the FGD, along with several subthemes (Table 2).

3.1. Use of modern and traditional family planning methods

Most women were aware and some had used modern family planning methods which were introduced to them by healthcare providers at the health facilities. The commonly used methods by these participants were pills, injections and calendars. Despite the awareness, some women acknowledged not using any of the modern family planning methods, rather they relied on traditional methods such as separation from the partner and sexual abstinence for preventing unintended pregnancies. Some participating women reported to have used or heard about unconventional family planning methods that had been originally used by their generational ancestors. These women believed that these measures were effective and did not have side effects.

3.2. Use of strings, snares, and pigis

Participants from various tribes shared their experiences regarding use of traditional and unconventional methods. Some used a "pigi" (a small stick a person wears at their waist), and others used "kamba" (string) with medicine around their waist. An example of a belief from Bagamoyo (Mha tribe) was shared.

There is a lady when I was staying at Kinondoni, she said there is a string with medicine that she wears on her waist to protect her from conceiving, and once she took the string off her waist she conceived. FGD 1, R 4 Bagamoyo

A woman from Masaki (Mha tribe) described the use of kamba (string) as a traditional contraception method.

For instance, you don't want to conceive, traditional healers are tying you a string on your waist traditionally, and when you want to conceive you unknit it. FGD. 4 R 2 Masaki

Another woman (Ngendereko tribe) from Bagamoyo added:

There is one traditional contraceptive that I have been advised to use but it did not help me; another one I know are fruits that were taken as

Table 1
Participants' sociodemographic characteristics.

Setting	Age, years	Participant	Religion			Education		
			Muslim	Christian		Primary	Secondary	None/dropped
Chalinze	20–30	1	1			1		
	31–40	2	1	1	2			
	41–50	2	2		2			
Bagamoyo	20–30	1	1		1			
	31–40	3	3		3			
	41–50	1	1					1
Masaki	20–30	2		2	1	0		1
	31–40	3	3		2			1
	41–50	0						
Kisarawe	20–30							
	31–40	1	1		1			
	41–50	4	2	2	1	3		
		20	15	5	14	3		3

Rural: Chalinze and Masaki; Semi-rural: Bagamoyo and Kisarawe.

Table 2
Themes and sub-themes identified from the focus group discussions.

Themes	Sub-themes
1. Use of modern and traditional family planning methods	<ul style="list-style-type: none"> o Use of strings, snares, and pigs o Calendars o Breast feeding linked to family planning o Men as heroes for having many children o Men not having time to attend clinic o Conflicting sources of health information
2. My husband will love me more if I give birth to more children	
3. Men's expected roles in family planning	
4. Provide education to dispel myths	
5. Religious barriers	

family planning seeds, again this could not help. FGD 1, R 3 Bagamoyo

However, women varied in their perceptions and beliefs of the traditional/unconventional methods effectiveness. They indicated that various tribes have specific practices trusted as family planning methods. A woman from the Makonde tribe in Masaki shared her disappointment with traditional contraceptive practices.

I was told by Sukuma person from Kahama (my neighbor); for instance, I am about to deliver a baby, I should take piece of cloth and put onto my vagina to collect the first blood drops and tie the cloth tightly and keep in a container and keep the container. When you tie it means you tie your uterus you can never get pregnancy unless you take the piece of cloth out of the container and wash it until it becomes clean, or put it outside when it is raining so that all the blood will be washed out; but that method proved not helpful. I tried and I got pregnant. FGD 1, R 2 Masaki

3.3. Calendars

The use of calendars was seen as a “modern” family planning method by women. However, some women commented that the calendar was less efficient. A woman stated that:

Using [the] calendar, you count your days. You have to be careful to follow [the] calendar, otherwise you end up pregnant. FGD 3, R 4 Kisarawe

Another participant said:

Through using [the] calendar, there is a time you cannot have sex and there is a time when [if] you have sex you immediately get pregnant, you don't need to go to the hospital. FGD 2, R 4 Chalinze

3.4. Breastfeeding linked to family planning

Women in this study were aware that breastfeeding could prevent pregnancy and act as family planning method. Despite this, they testified that avoiding sex when a mother was breastfeeding was the most popular culturally-based means of family planning practices (could be by sleeping in different beds or living in different houses). A Mkwere tribe woman said that when a mother was breastfeeding, she must avoid sex because of the belief that it would cause retardation to the child, which is known in Swahili as “*kubemenda*.” This belief added to the dilemma that mothers felt in being forced to breastfeed their children, as failure to do so would cause poor growth and sickness for the child. This was clarified by a participant:

For my understanding, I know when a woman is breastfeeding is a way of preventing pregnancy, but the woman can have sex but has to be given a traditional medicine for the purpose of preventing a child from effects of retardation “Asibemendeke” due to breastfeeding a child when having sex FGD 3, R 2 Kisarawe

4. My husband will love me more if I give birth to more children

4.1. Men as heroes for having many children

Participating women believed that men took pride in the number of children they had; the larger the number, the more of a hero he was perceived to be by the community. At the same time, men were viewed as “selfish” and reluctant in participating and utilizing male family planning methods particularly vasectomy, as well as their involvement for reproductive health services in general. This was described by one woman, as follows.

We have been talking about family planning, he was against it and said if I want family planning I should just use it myself, but he was not ready. FGD 3, R 2 Kisarawe

However, some discussants had a perception that men with six to 10 children would be much keener to opt for male's family planning option such as vasectomy than those men with fewer children. Men's age and spousal union was seen as informing the number of children a family would have before opting for family planning services. Several participants shared their views on this topic, for example:

Vasectomy can be done after a man is above 45 years and has six or more children. He will be willing to practice vasectomy because the number of children is so big. FGD 3, R 5 Kisarawe

Women were also concerned about the difficulty of advising their husbands to opt for a vasectomy, as their own childhood had not provided any context for making such choices. In addition, the women saw young husbands and those with multiple wives as barriers to vasectomy uptake. A woman who was a third wife in an Islamic marriage said:

I cannot advise him because he is not yet more than 45 years and where he came from he used to have many kids; for example, I'm the third wife, I have three children, the second wife has five, the first one has six children, and the last wife has two. It is not easy to advise him for vasectomy FGD 2, R 2 Chalinze

Some women were afraid that a vasectomy meant that their husbands might become sexually dysfunctional while simultaneously wanting to have more children. The women observed their husbands being respected by the community for having many children. These tribal communities regarded such men as powerful, proud, and rich, as children provide support for farming and other family activities. Children were considered assets for future wealth and able to support parents in old age. A woman from the Bagamoyo district shared that:

Men with vasectomy cannot satisfy their wives, women find it a pleasure and feel to have sex frequently and have kids; if the men will practice vasectomy, some of their needs will not be fulfilled, and hence no more children. FGD 1, R 5 Bagamoyo

4.2. Men's expected roles in family planning

Women felt that their men had a role of providing financial support for their families, which justified their avoidance of attendance for

reproductive health services. They felt that this excuse freed men from reproductive health activities. Some women also raised concerns about the cost of living, noting that they hardly earned enough money to provide their daily meals; therefore, there was value in having fewer children. However, their use of family planning required negotiation and acceptance from their men folk. Some participants were keen to make their marriage “strong and peaceful” before using family planning, and they testified to involving partners to attend the reproductive health clinic together. A participant explained her situation:

When we all agree to use family planning [it] will make the environment more peaceful for both of us and will strengthen our marriage and increase truthfulness. FGD 1, R 2 Bagamoyo

4.3. Men do not have time to attend clinic

Participating women shared their views about men not having time to attend reproductive health clinics, and that men saw going to the clinic as “a waste of time” when they could be out earning money for their families. According to these women, attending the clinic took almost a whole day, which reduced the time that men could be at work. These women were engaged in small business, but remained dependent on their husbands.

My husband is not employed; he is a day worker, so if you want to take him to the clinic he is supposed to stop working for the whole day. FGD 4, R 4 Masaki

You mean he has to attend clinic and what about our food? He should go to work to get money for meals, because you can go to the clinic and find that there is a long queue. FGD 4, R 2 Masaki

4.4. Provide education to dispel myths

Given the widespread nature of the myths and misconceptions that discouraged men from opting for contraception, many women advocated for more reliable sources of information about male contraception. One woman said:

I am very sorry to say that he will never assist me in any of the reproductive health issues; for example, my husband has wrong beliefs regarding the effect of vasectomy on both physical and sexual ability. FGD 3, R 3 Kisarawe

Some participants pointed out the importance of “spreading knowledge” to make men aware of what a vasectomy was, and at the same time creating demand for the services.

Before starting using family planning you should involve your partner so as to get his/her thoughts, and attend the clinic together, and it is a good idea because each one gets first-hand information from the service provider. FGD 1, R 3 Bagamoyo

4.5. Conflicting sources of health information

Multiple and conflicting sources of information about family planning options and services was a salient theme in two FGDs. Most women relied on village rumors for information about contraception. However, some stated that they accessed health education and male contraceptive information from their phones and from the health facility. The FGDs suggested preference for these options was increasing.

I do get information from [the] health center, but sometimes I receive messages through my phone; there are some questions that am being asked about my health. FGD 4, R 5 Masaki

Health facilities and healthcare providers were seen by women as providing a credible source of health information to the community and most of them gained knowledge from group counseling they received

when visited clinic for children vaccinations. For example, one woman shared her experience with a health provider.

What I know due to poor economy, it is important you plan before giving birth; therefore, you need to sit with your husband in the clinic and decide. FGD 1, R 2 Bagamoyo

4.6. Religious barriers

Religion was seen by women as one of the biggest barriers to acceptance of family planning services. Women perceived that the use of family planning was against faith teaching and commands. They further described that most men considered the use of male contraception as breaking a religious taboo and would shy away from them. As one participant stated:

...But honest, according to [the] Muslim religion, it is not easy to sit with my husband and talk [about] issues concerning family planning, he will not agree at all; taking him to the clinic will be difficult for him, and it is the same case for all Muslim men from coastal region. FGD3, R 2 Kisarawe

5. Discussion

Our data shows novel and complex results of perceptions and beliefs of family planning practices by rural women from Pwani, Tanzania. Women were aware of some modern common family planning methods (pills, injection, intrauterine devices). The findings also indicated that traditional and unconventional methods of family planning (abstinence, calendar, breast feeding strings, snares and pigis) were still commonly used. Paradoxically, while women believed that large families were important for their future with their partners, they also wanted the more immediate financial security of smaller families and strong marriages. Whereas similar to studies conducted in other parts of Tanzania (Bunce et al., 2007) and other African countries (Ajayi et al., 2018; Lanham et al., 2014), the results of the present study uniquely highlight the men’s responsibility for income generation as deterrents to their attendance at family planning services. Though women in the current study knew about modern family planning, their utilization rates were low with a common preference to traditional and unconventional methods, also reported by Asare et al. (2017) and Ajayi et al. (2018).

There was a commonly belief amongst cohort of women that traditionally a mother must abstain from sex during breastfeeding to avoid pregnancy and interruption to the growth of her breastfeeding child. This was known in the local language as *kubemenda*. This result is similar to a study conducted in suburban Tanzania that also reported a belief about *kubemenda* and abstinence from sexual intercourse for about two years after child birth (Mbekenga, Pembe, Darj, Christensson, & Olsson, 2013).

This study found numerous cultural barriers to utilizing family planning services particularly for men. Women testified to men’s strong belief that contraception was primarily a woman’s responsibility. This contradicts the recommendations that decisions about pregnancy affect both partners, and the contraceptive burden should be shared for better women and families’ health outcomes (WHO, 2018; The United Republic of Tanzania, 2008). Male involvement in family planning use is also reported to be contradicted by negative perceptions, religious and cultural beliefs on family planning and gender norms within and outside Tanzania (Bunce et al., 2007; Kessy & Kayombo, 2015; Lanham et al., 2014). A Mexican study found that while male involvement in family planning was increasingly accepted, factors such as traditional gender roles, taboos, and religious beliefs remained challenges for some communities (Dansereau et al., 2017). Women in that study commented that female sterilization would be better, as it would leave men free earn income for the family (Dansereau et al., 2017). In contrast, in high resource settings women preferred to avoid health risks associated with

cesarean sections and sterilization, and relied on their partner having a vasectomy (Bertotti, 2013).

Women in the present study indicated that their husband would “love them more” if they gave birth to a large number of children. These results affirm Bunce et al., 2007 findings on reasons for delaying vasectomy which arose from the need for many children, which posed a powerful barrier to vasectomy uptake. Women also believed their men’s intentions to have many wives and children to symbolize prestige and power (man seen as a “hero”), and be a sign of richness and show that decisions regarding reproduction were more controlled by men. Studies in various African settings show similar results that fathering children is a sign of virility and prestige (Alemayehu, Belachew, & Tilahun, 2012; Shattuck et al., 2016), with children also regarded as a source of support in old age (Adongo et al., 2014). Studies in Nepal, reported that men hold authority in households and marriages, and their reproduction preferences outweigh those of their wives as husbands had the final decision-making power (Chapagain, 2006; Jennings & Pierotti, 2016). In the Hindu setting, children are valued for their contribution to work; sons are prepared for their important role in religious rituals and are sources of support in old age, whereas daughters provide care for their husband’s parents (Kelkar, 2013).

Importantly, women in the current study while testifying to being responsible for their own current family planning, also saw that they had a pivotal role in supporting their husbands’ adherence to reproductive health services. This meant that wives needed continuously negotiate with their husbands, including communicating knowledge of family planning derived from their own attendance at health services. This is consistent with other studies that found that women who attend family planning services were empowered to share knowledge with their husbands in the family setting, the community, and wider society (Christian Connections for International Health, 2017; Nwokocho & Bakare, 2014; Kishore, Misro, & Nandan, 2010).

Women in this study strongly believed that men would not have time to attend reproductive health clinics, as they were always occupied with earning money for the family. A majority of men in rural Pwani are in short-term employment and have a key role of providing financial support for their families. The result is similar with a study in India that reported women’s worries that their husbands may not be able to provide financial support for the family if were involved in male contraceptive use (Donta et al., 2016). Contrarily, men have indicated in another earlier African based study a willingness to participate in reproductive health services such as family planning (Kabagenyi et al., 2014).

The present study highlighted a lack of correct information and misunderstandings regarding family planning options. Women obtained much of their health information in the form of rumors from family members and friends. Several previous studies have indicated lack of evidence and accurate information to rural communities regarding family planning (Adongo et al., 2014; Apanga & Adam, 2015; Asare et al., 2017). These studies have shown numerous myths associated with family planning options, particularly for men, for instance, when vasectomy is conducted causes losing the ability to perform sexual acts and that part of the penis would be removed (Apanga & Adam, 2015; Asare et al., 2017).

Our results suggested that religion has a key role in discouraging family planning utilization. This cohort of women were predominately Muslim and saw contraceptive as against gods will, in particular uptake of vasectomy services. Previous studies in Tanzania (Frajzyngier et al., 2006; Mungure & Owaga, 2014) and other African countries (Shattuck et al., 2016) showed similar religious barriers. For example, in Southern Ghana, some religions were opposed to condoms or vasectomies as they were perceived as an infraction against God (Adongo et al., 2014). Internationally similar views were found in Turkey where women and men testified that opting for vasectomy was committing a sin (Kisa, Sava, Zeynelo, & Dönmez, 2017). Our findings indicate the need for an in depth consideration of the role of cultural beliefs and religious faith

in family planning use between spouses.

5.1. Strengths and limitations

The strengths of this study included the use of FGD that elicited rich and in-depth nuance cultural data. In particular, participants were motivated by fellow women to contribute during the group discussions. The potentially lack of confidentiality in FGD may have limited the amount of sharing for some women. Furthermore, the need to attend childcare needs by women who brought their children may have interrupted the flow of the discussions.

6. Conclusion and recommendations

Lack of adequate family planning information, beliefs on and use of traditional/unconventional methods, gender roles organization that influence decision and limit women choices of family planning methods and; socio-cultural and religious beliefs were main perceived barriers for family planning utilization in this cohort of rural women. Mitigation of these barriers depends on the engagement of various stakeholders including religious and community leaders. Reproductive health education to delivered to rural communities is must be designed to adapt socio-cultural and religious doctrines with benefits of family planning and health outcomes. Health service delivery need to address the prevailing perceptions and beliefs with emphasize on the partner communication and men’s involvement in reproductive health services utilization.

Further funding and policies supporting family planning should clearly promote viable and sustainable contraceptive options, and through provision of appropriate information and education. This would need to be conducted in conjunction with a shift in social and family norms to raise awareness about the importance of women decision-making regarding family planning. Furthermore, community health workers should focus on health education about the importance of spousal communication and support as determinants for men’s decision-making regarding family planning.

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Conflict of interest

The authors declare no conflict of interest.

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Ethical approval

Ethical approval was obtained from the Ethics Review Committee of the relevant university (Ref: XXX/2017/238/jl). Permission to conduct this study was subsequently granted by Pwani, Bagamoyo, and Kisarawe District Municipal Councils along with the relevant health facility management and village officers. All participating women provided written informed consent.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijans.2019.04.005>.

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