

Barriers to family planning service utilization in four emerging regions of Ethiopia: Community member's perspective

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Abstract

Backgrounds: Access to family planning (FP) services can face challenges from both the demand and supply sides. Improved family planning services, combined with consistent access to modern contraceptives, can reduce abortion rates, fertility, and maternal morbidity and mortality. According to recent findings, FP use is low in Ethiopia's emerging regions, making an analysis of barriers to FP use critical in order to identify underlying causes and propose relevant solutions. The purpose of this study was to look into the barriers to using family planning methods among Ethiopian women of reproductive age in four emerging regions.

Methods: Community and facility-based existential phenomenological study designs was applied. Male and female contraceptive users, religious leaders, community leaders, health care providers, and family planning coordinators were all included in the study population. Purposive sampling was used to collect data from 23 districts. Focus Group Discussions (FGDs), in-depth interviews (IDIs), and key informant interviews were used to collect data (KII). Data was recorded using an audio recorder, then transcribed and translated by facilitators, but validation was done by a third party. Using Nvivo software version 11, thematic analysis was used to create the themes and sub-themes.

Results: A total of 147 interviews/discussions were held with 252 individual participants (15 FGD, 80 IDI, and 52 KII). Three barriers to FP use were identified in this study. (1) Individual barriers include lack of knowledge, lack of decision-making, peer pressure, fear of side effects, and lack of time; (2) healthcare system barriers include lack of accessibility, financial support, guiding policy, and monitoring system; and (3) socio-cultural barriers include male dominance, desire for large family sizes, negative attitudes toward FP, nomadic lifestyle, and myths and misconceptions.

Conclusions: Individual, healthcare system, and socio-cultural barriers all contribute to the multifaceted nature of barriers to FP use. Addressing these barriers requires collaborative effort of policymakers, programmers, and implementers, as explained in FP accesses, advocacy, financing, context-based policies, and massive participation of development partners.

Key words: Barrier, family planning, emerging regions, Ethiopia

Introduction

Family planning (FP) helps to improve the reproductive health of women by reducing both maternal and child morbidity and mortality (Adane 2013). FP also helps couples and individuals to realize their basic right to decide in a free and responsible manner, when and how many children to have. Additionally, improved access to family planning services can contribute to improvements in educational and economic outcomes, especially for girls and women (United Nations 2015).

Access to healthcare services has four dimensions: availability, geographic accessibility, affordability, and acceptability (Republic 2019; Donnell 2014). Barriers to accessing FP services can stem from both the demand and/or the supply side (Jacobs 2012). Demand-side determinants are factors influencing the ability to use healthcare services at the individual,

household, or community level. Supply-side determinants are aspects inherent to the health care system that hinder service uptake by individuals, households, or the community. Moreover, demand-side factors reflect the concerns of human rights and social justice, recognizing that supply-side health sector reform has had limited success in improving the delivery of health services. Supply-side challenges are due to suboptimal functioning of health systems-reflecting problems within healthcare infrastructure, human resources for health (HRH), supply chains, health financing, health information, and governance (Jacobs 2012; Standing 2004; MoH- Kenya 2016).

The World Health Organization reported that short birth interval (<24 months) is detrimental to the health of both the mother and the child (Issue 2008). With better health and greater control over their lives women can take advantage of education, employment,

and civic opportunities (EDHS 2011). FP also influences child survival by impacting mother's parity, birth interval, birth order, and the duration of breastfeeding (Sharan 2009). Demand for limiting family size is driven by several economic, social, and cultural factors. At the individual level, these characteristics include ideal family size, current number of children, socioeconomic status, religion, and women's physical and reproductive health (EDHS 2011). Despite the aforementioned facts, many women in poor nations, especially those in Ethiopia's four emerging regions, are unable to effectively use family planning services (Jalu 2019). As a result, the aim of this study is to explore the barriers to FP use among women living in Ethiopia's emerging regions. Understanding these barriers is essential for identifying issues with the FP program and helping to develop implementation solutions.

Materials and Methods

Study area and period: The Benshangul Gumuz (BG) and Gambella regions in the west, as well as the Afar and Somali (S) regions in the east, were the four emerging regions of Ethiopia included in this study. While the BG and Gambella regions have predominantly agrarian populations, the Afar and Somali regions have predominantly pastoralist populations. The study was conducted in June 2018 and employed both a community- and facility-based cross-sectional study methodology.

Study design and study population: We used an Existential-Phenomenological study design and divided the population into two groups: local residents and health professionals working at various levels. The qualitative study included male partners (contraceptive users and non-users), reproductive age women (contraceptive users and non-users), and community and religious leaders. The category of healthcare professionals included Health Extension Workers (HEWs), nurses providing FP services, and FP coordinators at district and regional health bureaus. A sample size of 16 FGDs (four from each region), 80 IDIs (20 from each region), and 52 KIIs (13 from each region) was determined. A purposive sampling technique was used and carried out in the 23 districts of the emerging regions.

Data collection tools: Pre-tested guiding questions that constitute community perception towards fertility desire, community perceptions towards benefits of contraceptives, community perspective towards contraceptive use, perceived contraceptive accessibility, and barriers for contraceptive use were outlined. Training on how to lead group discussions, elicit participant replies, and transcribe audio recordings was provided to data collectors over the

course of two days. The data was captured on a tape recorder. The interview and group discussions were both held in a private setting. Interview facilitators translated and transcribed the data.

Data collection process: In each region, four HEWs, four nurses, and four FP coordinators were interviewed. Similarly, each regional health bureau had one KII with an FP coordinator. Only male partners participated in the FGDs, and each region had two FGDs with contraceptive users and two with non-users. Participants were chosen based on factors such as marital status, age, and contraceptive use history. For both male and female IDI participants, the primary criteria were a history of contraceptive use or non-use. Each region included four contraceptive users and four non-users, for a total of eight male IDIs. Similar procedures were used to select female IDIs. Both male and female IDIs were chosen with the help of HEWs. IDIs were also conducted in each region with two religious and two community leaders.

Data quality assurance: It is necessary to discuss the credibility, transferability, confirmability, and trustworthiness of the findings. To boost credibility, we held training sessions, daily teleconferences, and pilot interviews. In the meantime, a meeting was held with field researchers to discuss their perspectives on the conceptual analysis framework. The preliminary report was also presented at a workshop where some of the participants (HEW and FP coordinators) shared their thoughts. To ensure dependability, a second person reviewed coded themes to ensure coding accuracy. We used an Existential-Phenomenological study design to gain a better understanding of community members' experiences and perspectives on FP use. The investigators' field notes, memos, and photographs were used to triangulate.

Data Analysis: Data were transcribed and translated by the data collectors; notes taken during interviews were combined with audio record translation. An external source performed a reliability check on transcription and translation. Data was exported to the NVIVO version 11 software for analysis. The exported data was coded line by line, segment by segment, and paragraph by paragraph. When the coding system was finished, all coded items were grouped into themes and thematic analysis was used to describe the findings.

Ethics approval and consent to participate: Ethical approval was obtained from review board of St Paul's Hospital Millennium Medical College and official letters were issued from the Ministry of Health (MoH) and other subordinate offices. Verbal consent was obtained from each participant before proceeding to the data collection.

Results

Characteristics of the study participants: The qualitative study included 252 participants from 15 FGDs (N = 120), 80 IDIs, and 52 KIIs. With the exception of Afar, which only had three FGDs, each area had four FGDs. There were 32 men IDIs (16 contraceptive users and 16 non-users). Another 32 IDIs were administered to female respondents (16

contraceptive users and 16 non-users). Furthermore, 16 more IDIs were conducted with community and religious leaders. 16 KIIs were conducted with district FP coordinators, 16 with HEWs, 16 with facility nurse FP providers, and 4 with regional FP coordinators Table 1.

Table 1: Type and number of qualitative participants on FP, in Emerging regions, Ethiopia, 2018

Types of Qualitative Data	Afar	Benshangul Gumuz	Gambella	Somali	Total
FGD with husbands	3	4	4	4	15
IDI with husbands of FP user	4	4	4	4	16
IDI with husbands of FP non-user	4	4	4	4	16
KII with district FP coordinator	4	4	4	4	16
KII with HEW	4	4	4	4	16
KII with Nurse	4	4	4	4	16
IDI with female FP user	4	4	4	4	16
IDI with female FP non-user	4	4	4	4	16
KII with regional FP coordinator	1	1	1	1	4
IDI with community leader	2	2	2	2	8
IDI with religious leader	2	2	2	2	8
Total interviews	36	37	37	37	147

The findings show that communities have become more aware of and accepting of the use of modern contraceptives over time. Participants acknowledged the value of using contraceptives despite the low rate of FP usage, particularly mentioning how it can boost household income, improve women's and children's health, and promote household food security. Participants felt that women are more likely than males to be aware of and intend to use contemporary contraceptives.

The data analysis revealed three barriers. Individual barriers include a lack of knowledge, a lack of decision-making, peer pressure, a fear of side effects, and a lack of time; healthcare system barriers include a lack of accessibility, financial support, policy guidance, and a monitoring system; and socio-cultural barriers include male dominance, a desire for large family sizes, negative attitudes toward FP, a nomadic lifestyle, and myths and misconception (Table 2).

1. Individual factor

Participants identified a lack of information, a lack of women's decision-making authority, peer pressure, fear of side effects, and being overly preoccupied with other activities as key individual factors preventing women from using family planning (Table 2). One of the main barriers to low family planning utilization, according to the participants, is a lack of knowledge, which is manifested by poor contraceptive acquisition and contraceptive misuse.

“Husbands are the decision maker for number of children that we would have. Because, in our culture women do not have a chance to decide about their number of children. My husband likes to have many children and hence I cannot do anything without I got permission on his side. When I asked my husband to allow me using contraceptive, he raised issue of religion. He permitted me after many pushes and I hope he understand that using contraceptive is good.”

women, contraceptive user, Somali region

Some women are also unsure of how to handle side effects and when to contact a medical facility. The low uptake of family planning in emerging regions has also been attributed to women's low educational status and the poor dissemination of health information. Another factor influencing contraceptive use is women's lack of decision-making power regarding the use of FP.

This report indicates that the primary decision-maker for family planning use varies by region. However, the majority of participants concurred that the husband was primarily responsible for deciding whether to utilize family planning and how many children each family would have. Few participants said that some women made the decision to use family planning independently of their husbands. Male influence on family planning use was reported to be higher for rural than urban residents. Despite this, some city dwellers said that the husband and wife would jointly decide

whether to use FP. Participants' responses revealed a significant need for contraception among women, with some claiming that despite their husband's influence on FP decision-making, some women chose to use contraception in secret. It was surprising to learn that traditional birth attendants, in some cases, also participate in the decision-making process for family planning use. Some Gambella respondents claimed that a traditional birth attendant has the authority to decide whether or not a mother should use family planning.

".....We need to get contraceptive which has less side effects. In addition, in our community there are many external influences that hinder us to use contraceptive. In our culture, men are decision makers and have great role to protect us from using contraceptives. My husband decides on me, and also he decides on every activity done in our life. There are many women who have interest to use contraceptive but refused by their husbands. Many of my friends are giving birth frequently, and have faced many health problems. Therefore, the government should work to make more comfortable and available for all contraceptive users". **Woman, contraceptive user, Afar.**

Participants of both sexes agreed that one of the most significant barriers to using contraception is still a lack of knowledge about its side effects. The participants' reported side effects of contraception were numerous and frequently reported in their communities. A male participant even mentioned missing his wife due to side effect. Women are frequently discouraged from using contraception due to concerns that they will experience heavy or irregular menstrual bleeding. Women were discouraged from using contraceptives after hearing potentially terrifying side effects or after experiencing significant bleeding while using them. Menstruating women are not supposed to engage in any personal or social activities, which causes a serious problem in the BG and Gambella regions. Even woman who have regular menstrual flow should avoid all social interactions until her cycle is finished. According to these cultural beliefs, people can become ill if they consume food cooked by a menstrual mother. This cultural taboo encourages the removal of long-acting contraceptives as soon as possible if people believe that using contraceptives will cause bleeding, in addition to contributing to poor contraceptive use. Women are discouraged from using contraceptives because they are concerned that using them will result in heavy or prolonged menstrual bleeding. This taboo affects women from GB and Gambella, and contraceptives that prolong or cause intermenstrual bleeding are not tolerated in these groups. Participants also mentioned that some women tend to remove or

discontinue using their contraceptive methods if they learn from their friends that the contraceptive causes bleeding or other negative effects, and that they prefer natural methods instead.

"They think they will get sick if they eat the food prepared by menstruating mother. The district health office has given much training to the kebele/community leaders on the bad cultural practices including this one, but they did not have behavioural change. Persistent and intensive health education is needed to control these problems" **KII, HEW, Gambella**

Another myth about modern contraception is that certain contraceptives, such as those that require injection for administration, cause covert bleeding, which leads to an infection that kills the mother. Some participants claimed that some community members believe that using modern contraception causes infertility, discouraging women from using them. The natural method, on the other hand, was preferred because it does not result in infertility. Furthermore, some FP procedures that involve inserting directly into a woman's uterus cause women to be self-conscious about baring their privates, discouraging them from using the contraceptives. In the Muslim community, the term "MUSA" refers to "the thinking of prophet MUSA," and it states that women should not expose their bodies while being encouraged to have as many children as possible. If using a contraception method causes menstrual bleeding, MUSA's strife is blamed. As a result of concerns about using contraceptives that are linked to religious beliefs, women use FP more conservatively. Community influence in general, and family and peer influence in particular, had a negative impact on FP consumption. According to this report, relatives such as mothers-in-law heavily influence women's use of FP methods, resulting in higher birth rates. The majority of family planning users reported community challenges, confirming that FP users can face stigma and discrimination not only from their relatives but also from other non-users.

"My previous wife had used contraceptive method but her menstrual bleeding got increased, and she seriously got sick and finally died. My new wife is also taking contraceptive but she still has bleeding. The menses comes twice a month and it is not good if the women do not eat balanced diet." **Male FGD participant, BG**

Participants also indicated that there are women who are unable to properly administer and use contraception due to their domestic workload.

2. Health care system problems

Poor services, accessibility, lack of transportation, low financial support, service-related problems (limited choice, limited supply, no static service, poor attention, poor counselling, low number of trained staff), a lack of guiding policy in FP, and a low monitoring system were mentioned as critical problems in the health care system. Accessing family planning services in emerging regions frequently necessitates long-distance travel due to the widely dispersed population. Geographic and topographic constraints affect both supply and demand for FP. It is difficult not only for individuals to find transportation to health facilities, but also to provide medical supplies to health facilities. According to the majority of respondents, the current low FP utilization is due to poor transportation, a lack of roads, and long distances to health care facilities. Long distances, limited transportation options, and poor road access, according to interviews with nurses and FP coordinators, all contribute to a lack of available FP methods, which contributes to low FP utilization. In the meantime, due to the transportation issue, there is insufficient supportive supervision at all levels.

“Because of distance and difficult topography, it is difficult to conduct supportive supervision....the land form is not accessible to transport, especially during the summer time, we stop long acting FP and provide them short acting FP since there are no bridges over rivers. Health professionals may find it difficult to travel by foot to provide service there.” KII, FP coordinator, Afar

Health-care issues were also mentioned as major contributors to low FP utilization. According to participant responses, health-care problems are

characterized by limited contraceptive options, low medical supply including guidelines, a lack of static FP service, a lack of attention, poor counselling, and a lack of trained staff. A major cause of low FP utilization was identified as a lack of funds at the health facility and health administration levels. Participants stated that, despite having good plans and strategies, they were unable to implement them due to budget constraints. Differences in FP utilization were also attributed to socioeconomic factors, lifestyle, migration, culture, different attitudes, residential areas, and mistrust of health care providers by beneficiaries. Poor monitoring and the absence of clear guiding policies on FP for emerging regions, according to health professionals at various levels, also contributed to low FP service coverage. They also stated that no special FP guidelines existed for emerging regions. Some nurses even stated that their community lacked a context-sensitive FP policy.

“....in our institution mostly, short acting family planning users are in high number, so to shift to long acting contraceptives there is a lack of trained staff as it needs continuous training and supportive supervision.” KII, MCH focal person Gambella

3. Sociocultural factors

Sociocultural factors related to low FP utilization emerged as the third theme from various domains. The most frequently cited reasons for not using contraception were male dominance, a desire for a large family size, traditional practices such as exchange marriages, negative attitudes toward FP, a nomadic lifestyle, myths or misconceptions, and fear of adultery.

Table 2: Thematic result on Barriers of family planning utilization among women, Ethiopia, 2018

Theme: family planning intake is influenced by three main factors: these are individual factor, health care system problems, and Socio-cultural factors

Themes	Theme 1	Theme 2	Theme 3
	Individual factors	Health system factors	Socio-cultural factors
Domains	1. Lack of knowledge 2. Reduced decision-making power among women 3. Family, social and peer influences 4. Fear of side effects 5. Being busy	1. Poor services accessibility 2. Service-related problems 3. Low financial support 4. Lack of context-based FP policy 5. Low monitoring system	1. Male dominance 2. Desire for large family size 3. Poor attitudes towards FP 4. Being Nomadic 5. Myth or misconception

All household activities are controlled and managed by the husband. This includes the decision to use FP methods, which is also under the husband's jurisdiction and control. Women expect their partners to start using contraception right away. Almost all participants agreed that a woman should obtain permission from her husband before using FP

methods. The husband's role in FP monitoring occurs both before and after the decision to use contraceptive methods. According to participants, women who use contraception without her husband's knowledge may face divorce, physical assault, early removal, family conflict, polygamy, and mistrust (Figure 1).

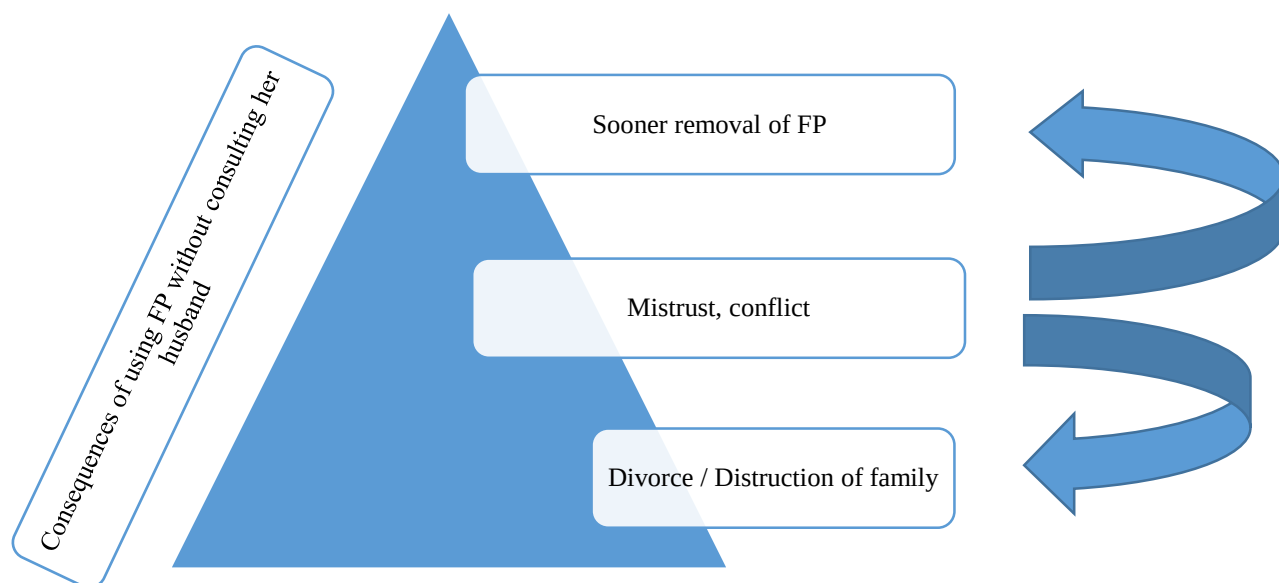


Figure 1: Conceptual framework on consequence of woman using FP without consulting her husband

Another factor that contributes to low FP utilization is the desire for a large family. The ideal family size for men, according to this study, ranged from 3 to 100 children. Participants who want a large number of children want to marry as many wives as possible. Communities prefer to have a large family size in order to compete inter- and intra-clan. As a result, clan leaders forbid their followers from using FP methods to grow their clan. Religion has also been linked to socio-cultural factors that prohibit the use of contraception in order to adhere to the Bible's statement that "children are God's gift". Religious leaders have a strong influence on the effect of socio-cultural factors, and the majority of participants advocate for the use of high-ranking influential religious and clan/community leaders to provide education in their community to improve FP intake.

"... well, it is God's decision. It is God that can let me have children from my husband;.... children come from God and husband; when your husband meets you, you will have a child but if he doesn't, you won't have children. Your children depend on your husband. Both your children and husband depend on God. It is God who can give us both."

IDI, Women FP user, Somali.

Some families may choose not to use contraception for religious or cultural reasons. According to this finding, a man in the BG region can have as many wives as his sisters. For example, if a man has three sisters, he can marry three brides through the exchange marriage system. This is common in the BG region. A family does not need to use contraception to have a large number of daughters to ensure that their boys have enough wives as a result of this exchange marriage. A son may be unable to find a wife if he does not have a sister or sisters. This cultural custom encourages every family to have as many daughters as possible.

Female participants reported that modern contraception requires a balanced diet, with failure to do so having negative health consequences. As a result, women believe that those experiencing a food shortage should not use contraception to avoid the negative consequences of contraceptive use. Another common misconception is that some people believe the provision of FP is done to protect the government's interests. Despite their desire to increase the birth rate, some participants indicated that the community is still not convinced by the government's rationale for population reduction. Some people believe that using family planning means killing an already conceived life, and thus some religions consider it sinful. Another

finding in this report indicated that allowing a wife to use contraception is equivalent to allowing her to commit adultery. The belief is that if a mother uses contraception, she will have long birth interval, making her healthy, beautiful, and appealing to other men. As a result, she may become the object of solicitation, which could lead to adultery.

“.....when a woman starts to use contraceptive, she becomes beautiful and she can care herself; this can lead some rude male individuals to sleep with her then her husband may catch them and this can lead them to divorce. Male, user, BG

Discussion

As barriers to using family planning methods, three themes emerged. Individual barriers impeding women's use of FP methods have been identified as a lack of knowledge. Knowing where to get FP not only aids in decision making, but it also aids in understanding the health, social, and environmental benefits of FP. Inadequate educational coverage and FP-related health education in specific study areas can be blamed for the lack of knowledge in these areas. Participants also emphasized the shortcomings of the FP mass education program. Women who are unfamiliar with FP use are also unprepared to deal with any side effects that may occur as a result of contraceptive use. Other African studies have found that a lack of knowledge is a major barrier to women using contraception (Muanda 2017; Kabagenyi 2014).

Fear of contraceptive side effects, infertility, and self-consciousness about contraceptive use are all factors that discourage women from using FP. This suggests that communities in general, and FP users in particular, are misinformed about the risks of contraception. Studies from different regions across the globe (Lete 2007; Tiruneh 2016; Lwelamira 2012) also show similar findings, indicating that these barriers are global challenges to FP utilization.

The second barrier to contraceptive use was problems within the health care institution, which were characterized by insufficiently trained staff and a lack of static service for FP in health facilities. Emerging regions have a highly dispersed and nomadic population; the majority of mothers must travel long distances to access healthcare. Furthermore, FP services are not available at health facilities on a daily basis, making contraception difficult to obtain. According to a Bangladeshi study, distance is a barrier to FP use (Kabir 2013). Furthermore, because health workers are not trained on long-acting contraceptives, a mother who chooses long acting may return home without contraception. This discourages women from returning to health facilities and may discourage other women who hear similar stories from neighbors or

friends. Monitoring and supervision of FP services by district and regional health bureaus has been described as insufficient, implying that more effort is needed to improve the system in this area.

Because of culture, religion, and other social norms, the majority of Ethiopian women lack the power and agency to make decisions about FP use. In developing countries, decisions about contraceptive use are solely the responsibility of the husband. The majority of women cannot use contraception without their husband's approval, indicating that male involvement in FP programs is required for FP programs to be effective. Women have less economic power, making them dependent on their partner's income. As a result, if a mother uses contraception without her husband's knowledge, she may face financial consequences if her husband decides to discontinue financial support. In some cases, decision-making authority is delegated beyond the husband to mother and father in-laws, as well as community health agents. This lack of decision-making power can be attributed to a lack of knowledge about contraception and apprehension about the consequences of using it. Similarly, other studies confirm the husband's central role in FP decision-making (Silumbwe 2018; Abdalla 2017; Muanda 2017). Fertility rates have decreased as education and economic progress have increased, with educational opportunities for women serving as a long-term strategy to increase their decision-making power.

Previous work has identified (Silumbwe 2018; Bogale 2011; Endriyas 2018; Sharan 2009), cultural and religious factors such as the desire to have many children, male dominance, marriage by exchange, and the prohibition of menstruating women from participating in activities all serve as barriers to contraceptive use. Contraceptive use is also hampered by societal attitudes toward inter- or intra-clan competition, as well as the emphasis placed on increasing clan size. Furthermore, children are viewed as the providers and caregivers for parents in their old age, according to existing cultural beliefs and norms. The average number of children desired by a family in emerging regions supports this finding (MoH-Kenya 2016). Each family's average number of children desired ranges from 4.5 in Gambella to 10.6 in ES, indicating that Ethiopian population policy varies by region. Ethiopia is a patriarchal society in which men make the majority of decisions. Within Ethiopian culture, men have the decision-making power to use FP methods; contraception without male permission can result in social consequences such as divorce and/or conflict. Because of this fear, women typically delay making a decision about FP use until they receive approval from their husbands.

Other studies have found that partner approval and inter-spousal communication allow women to use contraception more frequently (Girum 2017; Sedlander 2018).

Another interesting finding in this study is the role that cultural practices like marriage by exchange and the banning of menstruating women from work play in discouraging contraceptive use. A son can marry as many wives as he has sisters, according to cultural practices in BG and Gambella. He can marry three wives if he has three sisters but no brother by bringing a wife in exchange for each of his sisters. This discourages contraception use by emphasizing the importance of having as many daughters as possible in order to provide sons in the family with wives. Women who have sons are put under even more pressure to have daughters in subsequent pregnancies. Furthermore, women in these areas are not permitted to work during menstruation. As a result, women who have heard about or experienced vaginal bleeding as a result of contraceptive use will stop using or be discouraged from using certain methods of contraception. Despite claims by health providers that the government is addressing the issue, it is still practiced in the community. This suggests that strong government intervention is needed to change these practices.

Religion was discovered to be one of the underlying causes of low FP utilization. Although religious leaders and participants did not directly quote text from the Bible or the Quran that discusses contraception use, they did mention the belief that God is the sole decider of when and how many children one should have. Some Muslim religious adherents associate contraceptive use with a verse in the Holy Quran (17:31) which says “*don’t kill your child for fear of poverty*”. This statement appears to be concerned with the process after the zygote is formed, whereas most methods of family planning intervene before zygote formation. This highlights the importance of detailed analysis in understanding religious script and educating religious leaders on contraceptive use in order to prevent misinformation from spreading.

Misconceptions about FP use are also a barrier to contraceptive use. Participants' misconceptions about contraceptive use include believing that it necessitates a balanced diet, encourages female promiscuity, fosters mistrust between couples, and causes infertility. This finding was consistent with other studies conducted in Ethiopia and around the world (Population Council 2009; Gebremedhin 2017; Mekonnen and Worku 2011).

Conclusions

Multiple factors such as lack of knowledge, disempowered women, peer influences, fear of side effects, overburdened, poor service accessibility, service-related problems, low financial support in FP, a lack of guiding policy, a poor monitoring system, male dominance, a desire for a large family size, negative attitudes, being nomadic, and myths and misconception, contributed to low FP utilization.

Recommendations

For long-term progress, policymakers, programmers, implementers, partners, and community leaders must all work together. An intervention focusing on overcoming individual barriers, such as raising awareness and empowering women, should be strengthened. Meanwhile, healthcare system barriers must be addressed by reinforcing primary health care services and inviting development partners to fill the gap. Social media can assist in breaking down socio-cultural barriers.

Competing interest: Authors have no any competing interest.

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