

BMJ Open Barriers to uptake of reproductive information and contraceptives in rural Tanzania: an intersectionality informed qualitative enquiry

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ABSTRACT

Objectives Access to reproductive information and contraception (RIC) continues to be a critical unmet need in Tanzania and impedes the realisation of reproductive health rights. This study examined key sources of RIC and the factors influencing their uptake by women in Mbeya region of Tanzania.

Setting This qualitative study was undertaken in a rural ward in a district in the south of the Mbeya region

Participants In-depth interviews were undertaken with 48 women users and 2 nurses working in a public health facility, and focus group discussions with 16 home-based care workers in the district. Participants were recruited through a local non-governmental organisation (NGO) in the region, and via snowball sampling. All interactions were recorded, translated and transcribed and sought to identify the available resources and barriers in using them.

Results Participants reported six main sources of reproductive information and contraceptives: public health facilities, NGO mobile clinics, other women, Mganga wa Asili (witchdoctors/traditional doctors) and Duka la Dawa (pharmacy). Women users and healthcare workers identified a range of individual (age, marital status and geography) and health system-wide factors shaping women's reproductive choices and preventing uptake of contraceptives. The study also revealed structural factors such as gender, ethnicity, indigeneity as key determinants of access and health seeking, placing women from Sukuma and Maasai communities in the most disadvantageous position. Historical social disadvantage, patriarchal social controls and the pressure to preserve sociocultural traditions that women experience in the Maasai and Sukuma tribes underpin their disconnect from mainstream services.

Conclusion Women's reproductive choices and their uptake of contraceptives are shaped by the interaction of a range of individual, household, institutional and structural factors. An intersectional lens enables examination of the ways in which these factors interact and mutually constitute disadvantage and privilege.

INTRODUCTION

WHO estimates that '214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method'.¹ The United

Strengths and limitations of this study

- This paper reports findings of a qualitative study informed by an intersectionality lens to examine factors influencing access and uptake of reproductive information and contraceptives.
- The qualitative study draws on both user and provider perspectives gathered via interviews and focus group discussion with 48 women users and 18 healthcare providers and analysis developed over a period of 2 years.
- Participants were recruited through a local non-governmental organisation providing services in the region. While this offered rich and situated perspectives on both provision and utilisation, it also implied that the majority of women interviewed had some, although limited, access to services, and, we could not recruit any nulliparous or unmarried women.
- The intersectionality lens also allows us to situate individual lived experiences of disadvantage within wider institutional and structural processes of disadvantage.

Republic of Tanzania is a low-income country in East Africa characterised by various inequalities based on class, geography (rural–urban), indigeneity and ethnicity (home to 120 ethnic groups) among others, which have a bearing on individuals' and communities' access to health information and care.² Barriers to reproductive information and contraceptives disproportionately affect marginalised populations including adolescents, sex workers and other indigenous populations.^{3,4}

According to the latest National Health and Demographic Survey, in Tanzania, knowledge of contraceptive methods is near universal with '99% of currently married women aged 14–49, and 100% of currently married men aged 15–49 knowing at least one method of contraception'.⁵ Yet, the contraceptive prevalence rate among currently married women is 38% and among sexually active unmarried women between the age of 15–29 years is

54%⁵. Tanzania's total fertility rate of 5.2 is consistently higher than the desired rate of 4.5, although this gap varies across regions (rural–urban) and socioeconomic differences.⁵

Empirical research in this field is limited; focused primarily on the northern region and specific population groups. There is a degree of consensus on the centrality of a woman's social positioning to the understanding of sexual and reproductive health (SRH) and their access to SRH services.^{6–8} Yet, studies have concentrated on singular aspects of social position; highlighting the influence of gender and/or ethnicity on access to reproductive healthcare, and more recently, effect of education,⁷ class and geographic location,² age^{3,4} and family structures.⁸

The study reported in this paper was aimed at understanding factors that determine women's access to and uptake of reproductive information and contraceptives in a rural ward in a district outside Mbeya city in the Mbeya region. Up until the 1950s, the population of this district was small and consisted mainly of Sangu, who are indigenous to these lands.⁹ In 1953 and 1960 two groups, predominantly Sukuma and Maasai, settled. Displaced from historical and fertile rangelands, the settlement of these groups restructured the societal organisation of the district by introducing pastoral livelihoods and making it more ethnically diverse.^{9,10}

We adopted an intersectionality lens to gain a nuanced understanding of the factors and processes that determine women's choices and utilisation of services and the different barriers women face in accessing reproductive information and contraception (RIC). Intersectionality theory seeks to challenge the view that social relations are experienced as separate roads^{11,12} and promotes an understanding that human beings are shaped by the interaction of different social locations, for example, race/ethnicity, gender, class, religion and geography among others.¹² Intersectionality brings attention to differences within population groups that were hitherto seen as homogeneous, allowing a more nuanced understanding of vulnerabilities and the complex nature of health inequalities.¹³ Intersectionality is regarded as a promising approach to the analysis of multifaceted power structures and relations that interact to produce and sustain inequalities in (health) experiences and outcomes.^{12–14}

METHODS AND PARTICIPANTS PROFILE

A qualitative study was deemed suitable for the exploratory nature of the study. Data were collected by the primary author over a period of 2.5 months in 2017. More in-depth and contextualised understanding of this data was developed over 2018 when the primary author was employed for full time by a Tanzanian non-governmental organisation (NGO). The improved understanding of the regional context and Swahili over the years was used to review the transcripts and add nuances missed in the initial analysis.

Forty-eight in-depth semistructured interviews were conducted with women accessing service in a rural ward and district in the Mbeya region, exploring their perceptions of available services, experiences of access and key barriers in seeking reproductive information and contraceptives. Participants were initially recruited through community health workers in the area, then snowballed as women participants directed the researcher to recruit other participants. Following interviews, women were offered refreshments or its monetary value in cash (equivalent to 1000 Tanzanian Shillings). Due to high levels of illiteracy and widespread fear of authority and sanction among women, written consent was forgone. Instead, researchers sought and recorded verbal consent. The interview question format was split into three components (1) demographic to document the social location of participants as they self-identified and examine how inequalities in access were stratified along these factors; (2) awareness and knowledge of SRH and community resources; and (3) community norms, experiences and barriers in accessing services. In addition, two interviews were conducted with nurses working in the closest public health facility and one focus group discussion with 16 service providers in the district. The interviews with nurses were informal interviews in the field and focused on who was accessing care in the government clinics and why. The focus groups enabled interrogation of provider perspectives on determinants of access and revealed their perceptions on the specific vulnerabilities and relative disadvantages faced by certain communities in the district. These also provided a nuanced understanding of health systems challenges and the patriarchal societal context in which reproductive decisions are embedded. The focus group was useful in validating themes and discussing key findings, complementing the individual user perspectives generated through interviews.

All results were transcribed. Transcripts were coded for recurrent themes and analysed using thematic analysis. Data were organised into three main categories, basic understanding of SRH, identified sources of information and contraceptives, and barriers accessing contraceptives. These three categories were then analysed using an intersectional lens to interrogate prominent axis of inequality identified (eg, ethnicity/indigenous groups, age, marital status, religion and education), their interaction, and how these influence knowledge and access of resources. Trustworthiness and credibility of the data was assured as the findings and analysis were checked by local NGO staff.

Patients and public involvement

Patients were not directly involved in the study design or plan. Since the research focus was identified in consultation with a local NGO with significant presence in the community, the study design indirectly benefitted from input of women in the community who expressed SRH services as a critical unmet need. This established the imperative for undertaking a more thorough investigation of who were most affected by poor access and

why. More direct public/user engagement was achieved during data collection where qualitative methods such as interviews enabled rich interactions with women users as well as service providers.

The primary researcher discussed the study findings with members of the community (mostly women users, village leaders and staff of local NGOs) and identified ways through which the identified barriers could be mitigated through local programmes. Ongoing interaction in the field has strengthened feedback loops to inform improvements in service delivery. This is being undertaken via discussion with community health workers, implementation of new projects to improve access to care and follow-up interviews with women user participants. The discussions held with community health workers translated into staff hosting informal focus groups/feedback sessions with women users to identify how the NGO can address the issues identified in the study. The feedback loops allowed the expansion of available services to better serve women.

RESULTS

Table 1 summarises the sociodemographic profile of participants involved in the study. Although unintentional, all women interviewed identified as married with at least one child, indicating the gap in services to reach (young) unmarried women and girls.

The use of modern contraceptives was reported as both covert and stigmatised. Fifty-four per cent of respondents indicated never having used contraceptives. Most women were able to identify different methods of contraceptives, with the injection identified as the most commonly used (27% women reported currently or having used). Condoms, while acknowledged, were not categorised by women as contraceptives and were the least used method. This could be attributed to the HIV prevention campaigns by government and NGOs that frame use of condoms largely in the context of HIV prevention, and also, as women reported, the lack of agency they have in condom negotiations due to household power structures.

...people will mostly use condoms to prevent the transmission of HIV (39, Sukuma).

Respondents identified various sources through, which reproductive information and contraceptives could be obtained, though recognised that information received is limited. These are grouped into six categories: Mganga wa Asili (witchdoctors/traditional doctors), schools, women in the community, public health facilities, NGO-run clinic and Duka la Dawa (or pharmacy).

The first point of information was other women in the community. While older women in the family were identified as a useful source, only women who had their mother/grandmother talk to them about periods and fertility indicated they would follow suit with their daughters. Mganga wa Asili was indicated by providers as well as women users as most used. Other women stated that they

Table 1 Participants demographic profile

	'n'	%
Age		
20–24	11	23
25–30	12	25
31–40	18	37.5
41–50	4	8.33
Unknown	3	6.25
Education level		
No formal education	14	29.17
Unknown OR unreported	1	2.08
Started primary school	14	29.17
Finished primary school	18	37.5
Started secondary school	1	2.08
Indigenous/ethnic groups (Note they are listed without any prefixes, in Swahili 'Wa' prefix, in ethnic languages some groups would prefer to use their own prefix)		
Safwa	9	18.75
Sukuma	8	16.66
Hehe	7	14.58
Sangu	4	8.33
Haya	3	6.25
Ndali	2	4.17
Maasai	2	4.17
Mixed ethnicity	1	2.08
Unknown	1	2.08
Other	11	22.92
Religion		
Christian	15	31.25
Roman Catholic	1	2.08
No religion	14	29.17
Unknown	18	37.5
Number of children		
1–3	20	41.66
4–6	14	29.16
7–9	8	16.66
10 and above	3	6.25
Did not report	3	6.25

are not prominent in this district, which the healthcare providers in the area attributed to not wanting to admit to using local medicine. Public health facilities were a source for pregnancy-related issues, though women reported accessing clinics only in situations of emergency. The NGO clinic was the only modern medical service not seen in a negative light and indicated as reliable. **Table 2** lists these sources along with a description of their strengths and limitations as identified by participants. Not all sources were used to the same extent by all respondents;

Table 2 Information sources and services used: strengths and limitations

Resources identified for reproductive information and contraception	Used for	Groups using/excluded
Clinics run by local non-governmental organisation	<ul style="list-style-type: none"> ▶ STIs, contraceptives and pregnancy-related information 	<ul style="list-style-type: none"> ▶ Reproductive aged married women; mostly mothers
Duka la Dawa (pharmacy)	<ul style="list-style-type: none"> ▶ Medicines and occasionally information on STIs and contraceptives 	<ul style="list-style-type: none"> ▶ Reproductive aged women ▶ Young unmarried women use these services secretly
Public health facilities	<ul style="list-style-type: none"> ▶ Antenatal services; not seen as a source of information ▶ Clinics in the ward are first point of contact ▶ The closest health centre (outside the ward) is a source for STD testing (which is not available at the clinics) ▶ Hospitals (two wards away) were viewed as offering better services for maternal health. 	<ul style="list-style-type: none"> ▶ Only 25% women reported accessing public health facility for pregnancy care ▶ Public hospitals used by married women with supportive husbands who are willing to bear transportation costs, while geographical distance of Clinics make them more accessible to women seeking service without husbands' knowledge ▶ Sukuma and Maasai women indicated higher discomfort accessing local public health facilities, Maasai women tend to go into the city of Mbeya to access larger hospital for emergencies
Women in the community	<ul style="list-style-type: none"> ▶ Information regarding pregnancy and menstruation (older women as a resource) ▶ Contraceptives and sexual health issues (peers) 	<ul style="list-style-type: none"> ▶ First point of accessing information for most participants ▶ Young girls relied on peers; reproductive aged women relied on older women ▶ Only 48.83% of respondents indicated they were comfortable talking to their daughters about reproductive issues including fertility and menstruation
Schools	<ul style="list-style-type: none"> ▶ Basic information on reproduction through curriculum, though participants reported potential changes to add more SRH for younger generations 	<ul style="list-style-type: none"> ▶ Only reaching young girls ▶ Cited as a potential reason for mothers' not discussing SRH issues with their daughters at home
Mganga wa Asili (witchdoctors/traditional doctors)	<ul style="list-style-type: none"> ▶ Minor illness such as fever and STIs ▶ Local medicines for fertility and pregnancy prevention, and abortions 	<ul style="list-style-type: none"> ▶ Identified by both providers as well as many women users as being the most used ▶ Most used by Sukuma and Maasai women; abortion services were most used by younger women ▶ Not used by Christians, with the exception of Maasai women

SRH, Sexual and Reproductive Health; STD, Sexually Transmitted Disease; STI, Sexually Transmitted Infection.

and important differences emerged in women's access and experience of services.

The following section examines the factors that influence the use of contraceptives and information related to reproductive health.

Age and marital status

As age and number of children increased, using contraceptives was deemed more socially acceptable. This was confirmed as women with one or more children were more likely to start birth control. Women in their 30s recounted stories of having to turn to elderly women in the community or travel far distances to access their families for information because they were isolated in their husband's village, and highlighted the struggle for older women to access information about their body. They

were, therefore, far more reliant on family information pathways than any other group.

Use of contraceptives among young unmarried women/girls was highly stigmatised, while being sexually active prior to marriage shamed and often associated with prostitution. Nurses confirmed that very few unmarried or childless patients are seeking contraceptives, mainly due to cultural taboos.

Young women won't use any contraceptives; they would be reluctant to ask us for condoms as they would be shamed. If they are married, they understand the expectations and they are ready to give birth (Community Service Provider)

This indicates that young sexually active women are not accessing contraceptives, and thereby excluded from services offering sex-related and reproductive information. Consequently, and due to the illegality of abortion, young women were likely to rely on local medicine and practitioners, and use unsafe abortions in similar ways as modern contraceptives.

Socioeconomic status

The economy of the district where the study was undertaken is based on pastoralist subsistence farming or farm labour that most respondents' families engaged in. There were no significant variations in the socioeconomic status of respondents, who were largely from poor socioeconomic background. However, it translated to disadvantage in relation to education as well as their geographic remoteness from key community resources. The cost (and affordability) of services particularly for women who had to rely on their spouses for financial resources and to cover the distance to public health facilities emerged in most accounts.

I know about injections. I've never used but I would like to use. If not, you are always pregnant. I haven't used because it is too far [to access]. (25, Safwa)

The main issue for women to go the clinic is husband's attitudes, in the sense they don't have control over the money. Mostly, the husband has the money. So it's not that they are extremely poor but maybe the husband doesn't value going to the clinic so, unless the husband allows them and gives them money they can't go. (34, Mwehe)

With contraceptives, the men are creating barriers even if they don't know that his wife is using contraceptives. When she wants to go to the clinic it will be hard for her because she needs to justify why she needs to go to the clinic. (25, Safwa)

Navigating the gender–power relations in the household that determined control over resources and decision-making around accessing services was perceived more of a barrier than the actual socioeconomic status of each household.

Ethnicity

Ethnic disparity emerged as an important determinant of contraceptive use and access in the region; noted by both women respondents and nurse practitioners. Women from Sukuma and Maasai 'ethnic' groups were reported as facing highest burden and sociocultural barriers in using RIC. These findings corroborate with other research in Tanzania that identify Maasai as a historical marginalised minority ethnic group, and Sukuma, who tend to have the largest families, as most disadvantaged among ethnic groups.¹⁵

Two distinct pathways emerged that illustrated how ethnicity may influence uptake of RIC. First, interviews revealed the importance placed by the above groups on ethnic preservation of sociocultural tradition of large

families, upheld mostly by men who exercised social control in their partners' use of contraceptives to limit family size.

My husband would not agree to use contraceptives. In the Sukuma tribe, men are reluctant. (Sukuma, 23)

Maasai men would agree to using contraceptives if they have already given birth to many children. If they have a few, they will not agree. (Maasai, 40)

Second, women from certain ethnic groups, namely Sukuma, Maasai and Safwa, placed greater importance on local medicine and were more likely to use traditional contraceptive methods compared with other women in the ward. These include wearing sticks from Pige tree as a belt or specific jewellery, and drinking local herbal mixture. Religious beliefs intersected with ethnicity to inform health-seeking behaviours among women. While most Christian women denounced local practices and practitioners, for Maasai women, majority of whom were also Christians, traditional systems knowledge superseded their religious beliefs.

If people are not Christian or they don't go to church they can go ask traditional doctors. Those who go to church would go to the hospital to ask for information, if it is something serious. (31, Mguruka)

Many people, and women also, believe that traditional doctors work but my mom is a Christian. Being Christian I don't believe in traditional medicine. This is how I've been raised, since my childhood we've used modern medicine. (34, Mwehe)

Although ethnoreligious beliefs contributed to women's reliance on traditional practices, the remoteness and rural environment and their disconnect from mainstream services were critical factors making women turn to local medicine and practices. In this context, Mganga wa Asili was seen as more acceptable, trusted and readily available for reproductive health issues.

All women demonstrated extreme dissatisfaction with the lack of clinics in their village and distance to the nearest dispensary. Most respondents indicated distance and cost associated with travel as a significant barrier to accessing RIC, and all expressed a desire for a clinic in their village. Women indicated these obstacles are further exacerbated in adverse climatic conditions, and the furthest villages have no access to dispensary. Nurses reiterated distance as preventing women from attending clinics.

Still, villages are very far from the health center so it can be expensive or generally the distance prevents women from coming. (Nurse Practitioner)

Most women indicated satisfaction and comfort with the NGO-run clinic, and wanted the range of services to be extended. A mistrust in public health facilities was reported because of the poor and inconsistent availability of contraceptives, and lack of adequate monitoring and follow-ups.

Women also reported not being treated well by healthcare workers.

The nurses are not kind with the patients. So, I am not comfortable, I don't trust them... (Safwa, 25)

Only 12 women (25%) reported positive experiences at public health facilities in the ward. From respondents' profile, these were women who were older, had at least one child and had completed primary education.

I have used injections and have learnt about contraceptives in the health clinics. The nurse explained that after giving birth I should breastfeed for two years and then take a break for one year. So that's why I am using. (Sangu, 38)

Historically disadvantaged ethnic groups reported a particularly estranged relationship with the health system. Sukuma women indicated feeling discriminated at health facilities as they came from poor socioeconomic backgrounds, were not educated and lacked support from their spouse. Sukuma women who recounted giving birth in clinics as a positive experience were from urban areas outside of the district.

I don't feel comfortable thinking I go there and the nurse will have time or give me right information. Some nurse can say the injection isn't good and they can tell you to just get pregnant. So we don't understand sometimes what's the truth. (Sukuma, 39)

Women find it hard to go to the clinic because maybe their husbands won't be supportive. Some people don't have the money for the health insurance, without the health insurance they won't be provided with services. (Sukuma, 22)

Nurses emphasised education levels and ethnicity as being important deterrent for use of RIC and shaping women's ability to understand the information given. All service providers indicated Sukuma women as an ethnic group who either did not seek or were not allowed to access reproductive health information.

The main issues for women, especially those from the Sukuma tribe, it's hard to talk to them about contraceptives. It's hard to even provide health information because they will say they aren't allowed to take them because of their husbands. Or the majority won't choose (Nurse Practitioner)

Women participants on the other hand indicated ethnic diversity in their communities as leading to a better understanding of and change in health seeking behaviours for SRH. As women from different ethnic backgrounds socialised and shared experiences, there was hope that isolated ethnic groups, mainly Sukuma and Masaai, will be influenced positively by gaining access to information and hearing experiences of women accessing health services.

Gender norms and sociocultural practices

Due to the lack of access to formal education and view of marriage as a source of income and security, young women are often coerced into early marriage.

I never learnt anything about my body, period or other issues. I was married really young, maybe I was 10 years old, even my breast hadn't grown yet. (Sukuma, unknown age)

The average age of marriage in this area, or to start having children is 15 years. If a girl's body has gone through puberty and her body develops, she would usually get married (Community Service Provider)

In this context, children will go to primary school. Secondary school is still too far, if they fail then parents will start to think there is nothing for them to do but getting married. (Community Service Provider)

Women's subordinate position in a distinctly patriarchal family structure and the widely prevalent practice of payment of bride price create a high expectation for women to fulfil marriage duties by bearing children, and limit their influence in decisions around childbirth, which were largely made by their husbands. This is seen in the demand and timing of contraceptives among married women with children, who are the primary group using contraceptives. A nurse confirmed this trend and shared that she had given contraceptives only to women who had given birth. The social implications of not bearing children, such as desertion by the husband or stigmatisation by the community, outweigh the perceived benefits of contraceptives.

One challenge women face is pregnancy. According to tradition they are expected to have a baby. If they could choose they wouldn't want a child that early. So after the first kid, they want to use contraceptives (Sukuma, 39)

After that [C-section birth] I put an implant but had to remove it before the three years because my husband was refusing and wanted more kids. So I removed it due to the pressure and got pregnant (Safwa, 20)

The desire of participants to delay childbirth and access contraceptives sooner is undermined by a complex patriarchal system and limited agency of women when seeking healthcare. Women reported difficulties in using clinics due to associated transport costs, which husbands refused to pay if they did not see value in these visits.

If girls or women have these issues they can go to the clinic but the problem is many times the partner are not allowing them to go. So, they won't get the proper information or service they need. (Sukuma, 39)

On occasions, women shared that they attend clinics or use contraceptives secretly when they are able to save money.

...In my case, I use contraceptives, I use injections but my husband is unaware because I think my husband wouldn't agree. (36, Matulu)

Some women and care workers indicated that more educated and less traditional husbands are more accepting of their wife using birth control, mostly injectables, not condoms.

DISCUSSION

This study set out to understand women's experience of access and use of reproductive information and contraceptives in a rural district in Tanzania. Findings reported above demonstrate a range of factors operating at individual and household, and institutional or system level that influence women's reproductive choices and prevent their uptake of contraceptives. A distinctive contribution of this study, however, is to reveal the situated effects of mutually constituting and overlapping systems of power and discrimination in the lives of women in a rural part of Tanzania. Findings affirm that these factors do not operate in isolation but interact with each other producing distinct pathways of vulnerability and disadvantage, or privilege, relating to various domains of power; identified in this case as interpersonal, institutional and structural.

The differences in age groups, and its interactions with various structures of inequality mainly, ethnicity, religion and marital status demonstrate the complex relationship of factors that influence the experiences of accessing RIC. While young women were at a disadvantage in seeking contraceptives, there were important marital status and ethnicity-based differences that accorded differential privileges. Married women, for instance, felt socially pressured to bear children soon after marriage, thus prohibited from using contraceptives until having borne the first child or the number of children desired by their husband/family. Single women on the other hand face societal sanctions and stigma in seeking RIC as they are expected to abstain from sex until marriage, and therefore missed by both public health facilities as well as NGO services. The results indicate three underlying causes: the inaccessibility of formal education (and on sex, reproductive health and relationships), restricted communication space including in families and the stigma attached with this demographic accessing public services outside the social norm of accessing RIC after giving birth. These factors, also corroborated by other studies from Tanzania,^{3,8} limit young women's ability to ask for family planning through mainstream services, increasing their reliance on peers and perpetuating the cycle of misinformation, or on traditional medicine for abortions. Study participants' reference to the exclusion of young unmarried women resonates with the findings of other studies. For example, a study in the Mwanza region found that young women would conceal their sexual activity due to social repercussions of accessing modern contraceptives, and use traditional means to abort in case of an unwanted pregnancy.¹⁵ Once pregnant, receiving antenatal care at clinics is often the first opportunity for women to receive information about the body, contraceptives and breastfeeding. At reproductive age, women may access information through these clinic visits, but are still restricted by their partners.

The disadvantage was even more pronounced when examined for women's ethnic status and religion. Relative to other ethnic groups, historically, Sukuma and Maasai are more isolated¹⁰ and have a greater reliance on traditional knowledge systems. This, in part, results from a disconnect with formal health services and access-related challenges. Sukuma and Maasai households tend to have larger families, and lower child nutritional statuses across ethnic groups.¹⁰ The remote geographical location of the study site and limited opportunities to continue formal education underpin the preservation of sociocultural practices such as early marriage. The latter were more prevalent in women who either themselves or whose spouses had low or no education. Their isolation and relative marginalisation have led to their exclusion from formal services and discrimination from other ethnic groups and healthcare workers. This, compounded by the lack of support from spouses impedes Sukuma women's access to local clinics. Maasai women on the other hand lacked trust in formal health services due to a history of displacement by local authorities.¹⁰ Such historical disenfranchisement was largely ignored in nurses' accounts of women's inability to understand health information.

Adopting an intersectionality lens enabled us to go beyond individual factors and their role in shaping reproductive health disadvantage among women in this district. It, thus, prevented homogenising experiences (eg, poor access among 'rural women') based on one aspect of social location such as geographical remoteness. Instead, the study revealed the multiple sites and structures of power that interact to produce multiple levels of social disadvantage and privilege; exposing the links between individual lived experiences, institutional forces (eg, values, norms and practices sanctioned by religion, state and health systems) and broader political and economic environment. The significance of such multilevel analysis is evidenced in this study, which highlights that the lower uptake reported among Maasai and Sukuma women cannot be attributed solely to gender-power relations and social control experienced within households that prevent women from exercising choice in planning or spacing children. It is as much a result of their exclusion from mainstream development, and the historic displacement of these communities that has affected their relationship with, and trust in, public institutions such as the healthcare system, forcing greater reliance on traditional practitioners and practices. Reports from Tanzania, confirmed by organisations in the region, also suggest reduced access resulting from the cutbacks in reproductive health services prompted by loss of funding of family planning clinics and organisations as a result of implementation of the US Global Gag rule.¹⁶

To conclude, the acceptability and accessibility of contraceptives and reproductive information varied with women's age, ethnicity, marital status, religion, education levels, geographic location and power relations of the household. Navigating the patriarchal structure of the household to gain resources to access services was perceived a greater barrier than the household's socioeconomic status. Women's limited control over key household resources, compounded by marriage practices that isolate and distance them from their

natal home and village underscores the importance of understanding financial access or affordability through a gendered lens; an aspect missed in studies in Tanzania. It is well documented that women's individual choices on contraceptives are governed by gender norms and power relations within the household.^{3 7 15 17} Individual choices are constrained by economic, political and cultural factors, and are governed by a complex patriarchal system. These controls notwithstanding, the study also evidenced that women exercise agency by navigating the above barriers to access different information and resource pathways. Understanding these nuances in experiences is crucial in ensuring that research does not contribute to the discourse of presenting these women as powerless victims or passive non-users of contraceptive and reproductive services. In demonstrating that the social positioning of women is central to our understanding of access and responsiveness of services, the study establishes the need for policies and plans to address a wider set of inequalities at individual, institutional and structural level that impede realisation of women's SRH rights. It is critical that planners and local service delivery organisations be cognisant of these differences and overlapping disadvantages in designing and delivering services in order to prevent further exclusion and marginalisation. Ultimately, the secrecy and silence around contraceptive use and fragmented and weak resource pathways lead to the continuation of gender and ethnicity-based discrimination and the denial of women's sexuality.

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Contributors Both AC and AK designed and planned the study. AC collected data in the field. Both AC and AK analysed the data and prepared the manuscript. Authors acknowledge the support and contributions of the community health workers and staff members of the local non-governmental organisation who facilitated field work and provided inputs into working drafts of the manuscript.

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Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information. No additional data available. All data relevant to the study are included in the article—in the form of quotations and tabulated information—in findings.

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