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The views of Somali religious leaders on birth spacing – A qualitative study

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ABSTRACT

Background: Birth spacing is an important health intervention for women to attain good physical and mental health. In Somalia, religious leaders play a decisive role in approving or rejecting the use of family planning.
Objective: The study aimed to investigate Somali Islamic religious leaders' views on birth spacing.
Method: Qualitative individual interviews were conducted with 17 Somali Islamic religious leaders aged 28–59 years and analysed through content analysis.
Results: The main category that emerged from the analysis was that the concept "birth spacing should be used and nor family planning to be in accordance with the Islamic religion. Two perspectives of views of birth spacing were identified: accepted ways and unaccepted ways. The accepted ways include breastfeeding, use of contraceptives causing no harm to the women's health, and coitus interruptus. The preferred method should be determined by a joint agreement between the husband and wife, and that Muslim doctors should play a key role while the couples investigate their preferred method. Using contraceptives with the intention to limit the number of children was against Islamic values and practice. In addition, it was believed that using condoms promoted the temptation to engage in sex outside the marriage and was therefore prohibited.
Conclusion: According to the religious Islamic leaders, selected practice recommendations for contraceptive use is permitted in relation to birth spacing to promote the health of the mother and child. When providing professional contraceptive counselling to Muslim women, the word "birth spacing" is recommended to be used instead of "family planning".

Introduction

The Somali region has one the highest ratios of maternal mortality (732 deaths per 100,000 live births). The infant mortality rate is 72 deaths per 1000 live births [1]. The desired number of children for Somali families has been estimated as high as six per family [2]. In a recent Near Miss study conducted in the Somali region in 2015 the mortality rate at a local tertiary hospital was 1328 deaths per 100,000 live births [3], with the major causes of death being pre-eclampsia, hypertensive disorder, and obstetric haemorrhage [4]. About 22% of these deaths were stillbirths [5]. The rate of stillbirth is inconsistent with the stillbirth rates for the Sub-Sahara African and Southern Asia regions (35.5 stillbirths per 1000 live births [6,7]. Obviously, family planning is crucial in promoting the health of mothers and children. The use of contraceptives is an important instrument to control birth intervals and fertility and where all family members can enjoy physical and mental health and wellbeing to their full potential [8,9].

The Somali region in this study includes Somalia, Somaliland, and Puntland. In the Somali region the overall demand and uptake of family planning services have been found to be low [10]. According to the United Nation Population Fund, 1.2% of Somali married women used contraceptives, whereas 15–26% used traditional methods (e.g., breastfeeding) [10]. There are a limited number of doctors, nurses, and midwives counselling family planning in the Somali region. The pharmacies, however, distribute contraceptives and have reported that there is a public demand [10]. To our knowledge, no studies have yet investigated the views of Somali religious leaders in the use of family planning in a Somali population.

A common concern among religious leaders in Islamic societies has been whether family planning methods are used with the intention to limit family size, which is not consistent with Islam. Birth spacing, on the other hand, is permitted in Islamic society [11]. In many Islamic countries religious leaders have declared that birth spacing promotes a healthy mother-infant dyad [12]. Permission from religious leaders is

Abbreviations: LAM, lactational amenorrhea method

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required if women are to incorporate family planning into practise. Women enthusiastically used family planning when religious leaders in their community permitted its use. In contrast, women avoided family planning services in countries where religious leaders did not allow its practise [12–14].

In the Somali region religious leaders play a prominent role in approving or disapproving the use of family planning in the communities. Until now, there is a lack of information on Somali religious leaders' views on family planning use and fertility preferences. To permit the use of contraceptives is inconsistent with Islamic religious beliefs. Birth spacing, on the contrary, has been introduced in various Muslim countries [13,14]. Thus, for this study birth spacing will be used instead of family planning and contraceptive use. With this background, the aim of the study was to investigate Somali Islamic religious leaders' views on birth spacing.

Methods

Study design

A qualitative interview study was chosen to understand the different views of religious leaders in the Somali region towards birth spacing. Ethical clearance for the study was obtained from the Ethics Committee of Amoud University (Dnr 1-1-2015).

Setting and participants

The study was carried out in Somaliland. Purposive samples were drawn of religious leaders working in different mosques and Quran schools. The religious leaders were personally invited to participate in the study by the first and second authors (AE, OD). All 17 religious leaders that were invited agreed to participate and gave verbal, informed consent after receiving oral and written information concerning the study. The participants were holders of either a bachelor or master's degree in Islamic studies. The age range for the participants was 28–59 years old. The religious leaders were all married except one: the married participants had from 1 to 10 children. Their occupation was teacher, imam, or both at the mosque.

Data collection

The questions contained in the interview guide related to socio-demographic data, i.e. age, education, and work experience. The main question probed the religious leaders views on birth spacing. The same initial question was put to all participants: *What is your view about birth spacing.* After pilot interviews with two religious leaders, no revision was deemed necessary in the interview guide (the pilot interviews were included in the analysis). All individual, face-to-face interviews were conducted in the Somali language. The participants chose the place and time for the interviews. They were given a brief introduction about the study and informed that participation was voluntary and that they could withdraw from the study at any time. Confidentiality of the information they provided was guaranteed. All of the religious leaders, except two, allowed the interviews to be recorded with an audio tape recorder. The interviewers took notes during the two interviews that were not recorded in order to collect content. The interviews lasted, on average, 40 min.

Data analysis

All interviews were transcribed verbatim by AE and OD in the Somali language. The first two phases in the analysis process [15] were then conducted in the Somali language by AE, OD, and FO and thereafter the text was translated into English. The analysis process, inspired by Elo and Kyngas [15], started with several readings of the transcribed data. Sentences and words matching the aim of the study as well as identified recurrent themes were highlighted and entered into a spreadsheet. The meaning units were then condensed without the loss of nuance. After the condensed meaning units had been read and re-read, they were grouped into subcategories based on their similarities and differences. Thereafter, the text was translated into English by AE, OD, and FO. All authors contributed to the analysis process [15].

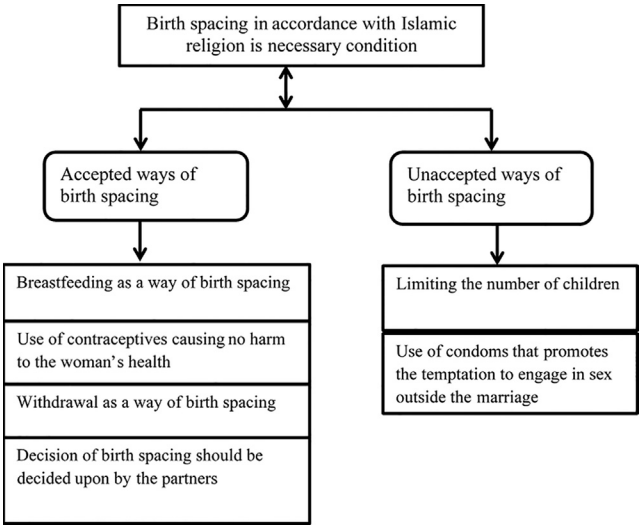

Fig. 1. Categories of Islamic religious leaders' views on birth spacing.

Results

Seven subcategories were identified. In the analysis process these seven subcategories were classified into two groups. From these two groups of subcategories, two generic categories emerged: *accepted ways of birth spacing* and *unaccepted ways of birth spacing.* As a result of the analytical process, including interpretation and abstraction, an overall main category combining the generic categories could be identified: *Birth spacing in accordance with Islamic religion is a necessary condition*. The overall main category combined the two generic categories and the seven subcategories

The main category that emerged from the analysis was: *Birth spacing in accordance with Islamic religion is a necessary condition* (Fig. 1). All religious leaders accepted birth spacing policies in general but only if they are compliant with Islamic religious beliefs. Birth spacing to limit the number of children and the use of condoms was prohibited because it was believed that such practices would likely promote sexual activity outside the marriage.

Accepted ways of birth spacing

There were several acceptable birth spacing interventions that religious leaders viewed as acceptable. Breastfeeding was regarded as the best method. Contraceptive pills were authorised as long as they did not harm the user's physical and mental health. They also believed that the withdrawal method (coitus interruptus) was useful. The religious leaders encouraged couples to agree on whether (or not) to use birth spacing. They declared that a Muslim health professional should, upon being consulted, decide on the best method for birth spacing according to the individual needs of the woman and family. In addition, the religious leaders proposed that Muslim doctors should consider both the health of the women and Islam religious beliefs in their decision process. These five accepted ways of birth spacing comprise the following five subcategories.

Breastfeeding as a way of birth spacing

The religious leaders confirmed that in the Quran (the holy book of

Islam) breastfeeding is mentioned 14 times as a method for birth spacing, demonstrating that the Quran supports breastfeeding as a birth spacing method. One of the religious leaders gave the following account of breastfeeding as a birth spacing method: *"We [my wife and I] used 2 consecutive years of breastfeeding to space the births of our children … that helped us and there is a 2-year interval between the birth of my children" (12).*

The religious leaders stated that breastfeeding before intercourse will decrease the chance of pregnancy; however, it is possible for a woman to get pregnant even when breastfeeding. The Quran repeatedly mentions the health advantages of breastfeeding for both the mother and the infant additional to the fact that it is a birth spacing method. Two years of breastfeeding contribute to the child's physical and mental wellbeing, and the mother benefits from the spacing of pregnancies. As one religious leader explained, *"Continuing with breastfeeding most probably disrupts women from menstruating. This gives them a break before another pregnancy, which means that if the women continue breastfeeding, they will most probably not become pregnant" (2).*

The religious leaders meant that breastfeeding for two consecutive years is not mandatory in Islam, but it is recommended for those who wish to do so However, for those children unable to breastfeed, other contraceptive methods were suggested for birth spacing.

Use of contraceptives causing no harm to the women's health

The religious leaders distinguished between birth spacing and family planning in controlling births relative to the use of contraceptive pills. They reasoned that family planning concerns limiting the number of children in the family, whereas birth spacing refers to the amount of time between births and/or pregnancies. The use of oral contraceptives was not prohibited in Islam, although the religious leaders noted that there had been cases in which contraceptive pills had detrimentally affected the health of the mother. The religious leaders agreed that the only time contraceptive pills should be allowed as a birth spacing method was if they did not increase the risk of health problems. One religious leader gave his view of the first (breastfeeding) and second choice solution (contraceptive pills): "*There is no need to give women contraceptive pills to achieve birth spacing because breastfeeding the child correctly by emptying the breasts of milk before having sex is enough to achieve the desired results" (17).*

Withdrawal as a way of birth spacing

The withdrawal method (coitus interruptus) can be used to space the birth of children if the couple agree to the use of this method. Withdrawal prevents pregnancies and facilitates birth spacing as religious leaders stated. If the method is used solely to prevent 'the will of God', it should not be used. The mutual standpoint of the religious leaders on birth spacing was largely in accordance with the following statement by one of the religious leaders.

> *Allah [the Arabic word for God] makes the ultimate decision regarding creation; withdrawal can prevent the woman from becoming pregnant. Thus, a distinction is drawn between whether the withdrawal method was used with the intention to limit the number of children or to space the births. This distinction is important when making the choice to use the withdrawal method (1).*

Decision of birth spacing should be decided upon by the partners

A decision that is jointly made by the couple is the most prudent approach to facilitate birth spacing. The decision as to whether to space pregnancies should be determined by the couple. However, the religious leaders had different beliefs on shared decision making in which both partners contribute to the decision-making process. One-sided decision making by either the man or the woman was considered undesirable by some religious leaders, as it might lead to problems in the relationship. When the couple collectively recognises the advantages of birth spacing, they reach a point where they share in the decision process.

> *Decision making that is fair and shared is the best way to make decisions on birth spacing. However, sometimes this may not be the case (e.g., sometimes the woman may express false complaints, telling the husband that she is sick and unable to have another pregnancy when in fact she is physically fit). The couples should be open and honest to build a strong and lasting relationship (5).*

Some other religious leaders stated that the husband had the decision-making power, but the majority of the religious leaders thought shared decision making is important in that it creates a strong bond between the couple based on partnership. As one of the religious leaders stated, "*…shared decision making is not a matter of quarrelling but it is like sitting together to discuss what is good for both of them, both the man and the woman" (13).*

Muslim doctors should play a role in birth spacing

The religious leaders felt that Muslim doctors should play a key role in any decision a couple makes regarding birth spacing. If, for health concerns, it is not advisable for the women to become pregnant again, the Muslim doctor can suggest the use of contraceptives to prevent pregnancy. Based on the doctor's recommendations, the couple will most likely follow this advice. If the woman decides to use medical contraceptive methods for birth spacing, she should consult with a Muslim health care professional knowledgeable about Islam and women's health and wellbeing. Again, differentiating between limiting birth and spacing birth is crucial.

Therefore, Muslim doctors are allowed to make birth spacing decisions while the couples investigate their own objectives for the intervention. The couple needs to consider how long a period the wife requires to recover after giving birth before becoming pregnant again. Some of the religious leaders mentioned that women often developed anaemia because of consecutive pregnancies and breastfeeding periods without spacing the children and therefore couples need to consider this issue. The responsibility of the husband was underlined in terms of allowing the woman to recover from childbirth and breastfeeding. An optimal birth spacing should be at least 2 years (preferably 3–5 years), which has advantages for both mother and child. A Muslim doctor may advise the couple to wait longer, depending upon his assessment of the women's health. One religious leader stated:

> *If the mother does not have or eat a balanced diet that will build her body and prepare her for having another baby, birth spacing is an option for her because the Islamic religion always protects the women and children and does not want to harm anybody (4).*

Unaccepted ways of birth spacing

The two subcategories under this generic category describe birth spacing as limiting the number of children and use of condoms that might promote sexual temptation outside the marriage and was therefore prohibited.

Limiting the number of children

According to some religious leaders, controlling the number of births is against Islam. At the same time, giving birth to many children is encouraged in the Islamic religion. The religious leaders described how limiting the number of children is considered a sin. One religious leader said, *"Using birth control is not only forbidden but is considered a deadly sin and a violation of Islamic law" (11).*

Use of condoms that promotes the temptation to engage in sex outside the marriage

There were many available and flexible ways of spacing birth without violating Islamic religious beliefs and thus there is no need to use condoms according to the religious leaders. However, one religious

leader was not against the use of condoms: "*I think that married couples can use condoms if they so desire. Condoms are not a big deal, and it is just like the withdrawal method" (9)*.

The reasons for not using condoms were that it might lead to outside marital relationships and encourages the use of condoms among young people. The primary intention for prohibiting condoms was to curb the temptation of young boys and girls to have sex before marriage. One of the religious leaders remarked:

> *I am totally against condoms. I believe that condoms cause diseases when they are used by young people without control. I don't trust the idea that condoms prevent sexually transmitted diseases. In my opinion, it leads instead to negative use and in that sense condoms are disgusting, insecure products used by the young and unmarried (6)*.

Discussion

This paper examined 17 Islamic religious leaders' views on birth spacing. The concept of birth spacing was viewed to be provided in line with Islam religious beliefs. The findings showed that two perspectives of views of birth spacing: *accepted ways* and *unaccepted ways of birth spacing*. The accepted ways of birth spacing include breastfeeding, use of contraceptives causing no harm to the health of the mother and her child, and coitus interruptus. Any decision about birth spacing is a shared decision between the couple, and that Muslim doctors should play a key role in any decision a couple makes regarding birth spacing. Using contraceptives with the intention to limit the number of children is considered an act against Islamic beliefs. The religious leaders were mostly concerned that the use of condoms encouraged the temptation to have sex outside the marriage. Therefore, these two approaches to birth spacing are prohibited. The religious leaders, however, did not address that birth spacing in relation to contraception and family planning is well protected under international human rights and humanitarian law [9]. UN Women is the global champion for gender equality and guarantees women equal rights in deciding on the number and spacing of their children, as well as to have access to information and education to exercise their rights [9]. However, according to the position of the religious leaders, they protected women's rights by only accepting contraceptives that did not harm the physical and mental health of women.

Our findings showed that breastfeeding was considered the most effective birth spacing interventions, as it provided women the necessary time to recover from pregnancy and childbirth. The family planning method that religious leaders recommended is the lactational amenorrhea method (LAM). LAM has been widely used in low-income countries, where it has been shown to be somewhat effective when women are breastfeeding fully in the postpartum amenorrhea period with an infant under 6 months of age [16,17]. However, there is still a 5% risk that women get pregnant within the first 6 months. Moreover, if the women do not strictly adhere to the LAM criteria, the risk of unintended pregnancy increases [18]. Hence, LAM is not a feasible family planning method and therefore written and oral information on alternative contraceptives, such as oral contraceptives and intrauterine device, is recommended [16].

The intention to space births/pregnancies was the central point expressed by the religious leaders in this study. If contraceptive pills are applied to space births, some of the religious leaders argued that the women could use them. The fundamental point of the intention to space the births is supported by the findings of Davidson's [19] and Kiura's [20]. These authors reported that Somali men were in general against contraceptives, but when they did use them, it was to space births and not to limit family size. In our study religious leaders were against the use of condoms for spacing births because of the temptation to participate in sexual activity outside the marriage. A study conducted with refugee Somali married men living in Finland [21] demonstrated that 63% of the men avoided using condoms because of their religious beliefs. This finding suggests the potential important role that religious leaders have on people's reproductive behaviour. Women's use of contraception is, consequently, influenced by society and what society believes to be acceptable [22]. For doctors, nurses, and midwives who counsel Muslim women, it might be of value to phrase language carefully considering the women's underlying birth spacing intentions. Studies conducted in Finland with Somali diaspora women [23,24] confirm the importance of addressing birth spacing in a culturally sensitive manner. Still, the intention must be to space the births and not to control or plan family size according to the religious leaders in the present study. This point is crucial as regards whether a woman should be allowed to use contraceptives. Somali women living outside the Somali region [23] reported a transition from not discussing or using contraceptives to discussing birth spacing. Some of the reasons for the transition were the availability of contraceptives and access to health services. Because religious leaders have a vital role in the Muslim society, there is a need to increase their knowledge on women's sexual and reproductive health, as well as their fundamental gender-specific and human rights.

Limitations

The study was based on 17 individual interviews with religious leaders and their views on birth spacing. In qualitative interviews, different experiences and views are important in order to obtain in-depth information. All the religious leaders interviewed were married (except one) and had children. Thus, their views might differ from those of unmarried religious leaders. Thus, the present sample could be seen as a weakness in the selection of participants. In this study, the term 'birth spacing' was used because it was acceptable in the Somali context, whereas the term 'family planning' was not. However, using the term 'family planning' might have been fruitful because it could raise other topics discussion. Somali-born Muslim men, registered nurses, and master's degree holders in reproductive health conducted the interviews. This could also be seen as limitation; however, because they had no relation to the study participants, this could be a strength instead. Furthermore, to keep in check any preunderstanding of family planning an ongoing discussion took place between the authors in the data gathering and analysis process by applying their cultural and professional competence to restrict potential prejudice. As described in the method section, the religious leaders were from one town in Somaliland, which might have reduced the variation in views of religious leaders in the Somali region. Thus, caution should be exercised when transferring these findings to other contexts. However, in the Somali region the context is similar in religious leadership. Moreover, the religious leaders did not work at the same mosque or Quran school and had different backgrounds and thus likely exposed to different experiences. No similar studies have been found with which to compare this study so that its credibility cannot be assessed. Despite these limitations, the study makes a valuable contribution by describing how midwives and physicians can support couples through family planning counselling. Further studies on a wider selection of religious leaders, including those of a younger age, may provide other perspectives on issues related to birth spacing. It is important to determine the reasons underlying choice of contraceptive devices from the women's perspective.

Conclusion and clinical implication

According to the interviewed religious Islamic leaders, selected practice recommendations for contraceptive use is permitted in relation to birth spacing to promote the health of the mother and child. When providing professional contraceptive counselling to Muslim women, the word "birth spacing" is recommended to be used instead of "family planning". The decision about birth spacing is a shared decision between the couple. However, Muslim doctors were allowed to make birth

spacing decisions while the couples investigate their own objectives for the intervention. Religious leaders in the Somali context need to increase their knowledge of women's sexual and reproductive health and rights.

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Conflicts of interests and funding

No conflicts of interest. This project was funded by Sida.

Authors' contribution

KE and FO designed the study. AE and OD were responsible for collecting data. AE, OD and FO analysed data with the input of KE and drafted the manuscript. All authors contributed to drafting and revising the manuscript, and all approved the final version.

Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.srhc.2019.02.003.

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