REVIEWS

The influence of personal, family and community and religious and cultural factors on couples' family planning decisions in Qatar and Islamic and/or Arabic societies

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Received: August 24, 2025 **Accepted:** November 24, 2025 **Online Published:** December 15, 2025
DOI: 10.63564/jnep.v15n12p38 **URL:** https://doi.org/10.63564/jnep.v15n12p38

ABSTRACT

Background: Family planning is important to foster maternity, infancy, and healthy children. A key goal in maternal child health is to improve the use of antenatal and postnatal services in a community. Both clinical practice and empirical literature indicate that many factors influence the use of family planning services. The Qatar National Health Strategy and Primary Health Care Corporation's goals are to deliver healthcare that more effectively empowers patients and families in making decisions about their health and wellness. Couples who have an in-depth understanding and knowledge of the impact of family planning on maternal child health are positioned to make fully informed decisions. Health providers' and educators' knowledge of family planning's impact is key in supporting families' decisions regarding family planning.

Methods: Whittemore and Knafl's framework was used to guide this integrative literature review. The search was conducted using five databases for peer-reviewed articles published between 2011 and 2022 as well as inclusion and exclusion criteria. The Mixed Methods Appraisal Tool was used to assess the quality of the studies. Data was analyzed using a thematic framework. The socio-ecological model was adapted and modified for data synthesis.

Results: A couple's participation in family planning is influenced by personal characteristics (knowledge, education, income), family and community (husband) as well as religion and culture. The influence of religion and husbands are paramount in decisions about family planning.

Conclusions: Understanding the factors that influence family planning decisions is essential to make informed decisions and provide effective interventions. Healthcare providers and program planners should consider these factors when developing strategies to improve couples' access to and utilization of family planning. The development and implementation of such strategies will require the input of all stakeholders, the inclusion of champions, and attention to the local context as well as more broadly to Islamic and Arabic societies.

Key Words: Arabic, Contraception, Culture, Education, Family planning, Gender, Husband, Knowledge, Muslim, Qatar, Religion

1. INTRODUCTION

The family is recognized by Islam as the core element of Islamic society.[1] Family formation is the responsibility of parents. Therefore, Islam has legislated marriage between a man and a woman. Prophet Muhammad said, "Marry women who are loving and very prolific, for I shall outnumber the

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peoples by you" (Sunan Abi Dawud 2050, Book 12, Hadith 5). According to Islam's perspective, a family has no specific size. Many Islamic families want to produce many children, which is their reproductive right. Embedded in customs and traditions, families boast about having many children, so women have multiple pregnancies with a short birth gap.[2] However, a short birth gap is associated with a high risk of adverse maternal, perinatal, infant, and child health outcomes such as an increase in maternal and neonatal mortality, stillbirths, and small for gestational age infants.[3,4] Birth spacing improves perinatal outcomes, child survival, maternal health, and long-term prosperity.[5] Islam allows spacing between children but forbids birth control. In Islam, spacing is temporarily permissible when caring for and raising children as well as avoiding health risks or stress that a woman cannot tolerate provided that the method does not cause side effects for the mother. The Qur'an, the first source of Shariah [law], states "Mothers may breastfeed their children two complete years for whoever wishes to complete nursing [period]" (Verse 233, Surah Al-Baqarah, Qur'an). The Qur'an recommends that mothers breastfeed their children for two years to recover their physical and psychological well-being before becoming pregnant again.[6]

Family planning (FP) is defined as having the freedom and responsibility to decide the number of children wanted while knowing how to prevent pregnancy.[7] According to the World Health Organization (WHO),[8] FP uses contraceptive methods and birth spacing to attain the desired number of children. WHO[9] statistics indicate that among the 1.9 billion women of reproductive age (15-49) in 2019, 1.1 billion required FP. Contraceptive methods were used by 842 million of these women whereas 270 million women's demand for contraception went unmet.[9] In Qatar, Arbab et al.[10] reported that 94.6% of Qatari women knew about contraceptives, but only 64.9% favored the use of contraception, one-third of the women did not use contraception, and what influenced their decisions was not described.

Most women in developing countries who would prefer to avoid pregnancy or delay it do not use contraceptives. According to the United Nations Population Fund Agency,[11] 60.5% of married Arab women wish to avoid pregnancy in the next two years after a birth, with 40% not using safe and efficient FP methods. These women cited a diversity of reasons, ranging from inadequate knowledge or resources to the absence of assistance from their partners or communities.

Many women in antenatal and postnatal clinics in Qatar report that their husbands refuse contraception. The husbands prefer more children, with a preference for sons, and having a big family living in one house. The mother-in-law is also influential in decision making, insisting that the husband has many sons to bear his name and remain linked to him in life.[6]

Many factors, including culture, ethnicity, and religion, influence an individual's health beliefs and use of FP.[12] Most religions are strict in the use of contraceptives and even prevent the use of permanent methods of contraception. Islam is a primary influence on the use of contraception. A Muslim believes that contraception interferes with *Allah's* [God's] plan; however, many Islamic scholars and *Fatwa* [legal edict] acknowledge that the spacing of births is also critical given the impact on mothers and infants.[13] This integrative literature review explores the socio-demographic, cultural, religious, knowledge, educational, and gender-related factors that impact couples' use of FP.

2. METHODS

An integrative review is a process that integrates previously separate research endeavors to create a more comprehensive and deep understanding of a phenomenon.[14] Integrative review helps to identify areas of improvement and provides a framework for collaboration and improvement.[15] This integrative review was guided by the five steps of Whittemore and Knafl's[15] framework which include problem identification, literature search, data evaluation including a critical review of articles, data analysis using a conceptual model, and presentation of results.

2.1 Problem identification

In Qatar, FP sessions are often attended only by the wife in Arabic couples. Attendance at FP services by the husband and wife would allow both to receive important information that promotes the health of mothers and infants and facilitates informed decision making about FP.

2.2 Literature search

A literature search was conducted using the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Embase, PsycINFO, and Academic Search Complete databases. An academic librarian assisted in the search process. The review limiters were articles published from 2011 to 2022 in the English language, scholarly peer-reviewed articles, primary studies, and quantitative, qualitative, or mixed-method studies that included adults between 15 and 49 years of age. The following keywords were used in the search: family planning, contraceptives, birth control, birth spacing, child spacing, Islam, Muslim, Arab, non-Arab, knowledge, attitude, culture, ethnicity, gender, and religion. The Boolean operators AND and OR were utilized to extend or limit the search.

2.3 Data Evaluation

Data evaluation included 657 articles. After removing duplicates and reviewing titles and abstracts according to inclusion and exclusion criteria (see Table 1), 253 articles remained for possible inclusion. Of these articles, 138 were eliminated after full-text review according to the inclusion and exclusion criteria. Further analysis of the remaining 115 studies was conducted by the author and her supervisor. Fifty-two articles were eliminated in this process, resulting in 63 articles (see Figure 1). Two reviewers critically analyzed each of the included studies using the Mixed Methods Appraisal Tool (MMAT) version 2018 to ensure an accurate quality assessment. This tool uses three criteria rather than a score: "Yes" meaning the criterion is met, "No" meaning the criterion is not met, and "Can't tell" meaning there is not enough information in the paper to judge if the criterion is met or not. All 63 of the studies included in this review were judged to have met the criteria.

Table 1. Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
• Studies published in English from 2011 to 2022 • Peer-reviewed studies • Primary and secondary qualitative, quantitative, and mixed method studies • Men and women between 15 and 49 years old • Arabic and non-Arabic • Muslim and non-Muslim • Married couples living together • Have at least one child	• Studies published in languages other than English before 2011 • Men and women less than 15 years old or more than 50 years old • Single women or men • Divorced or widowed • No children

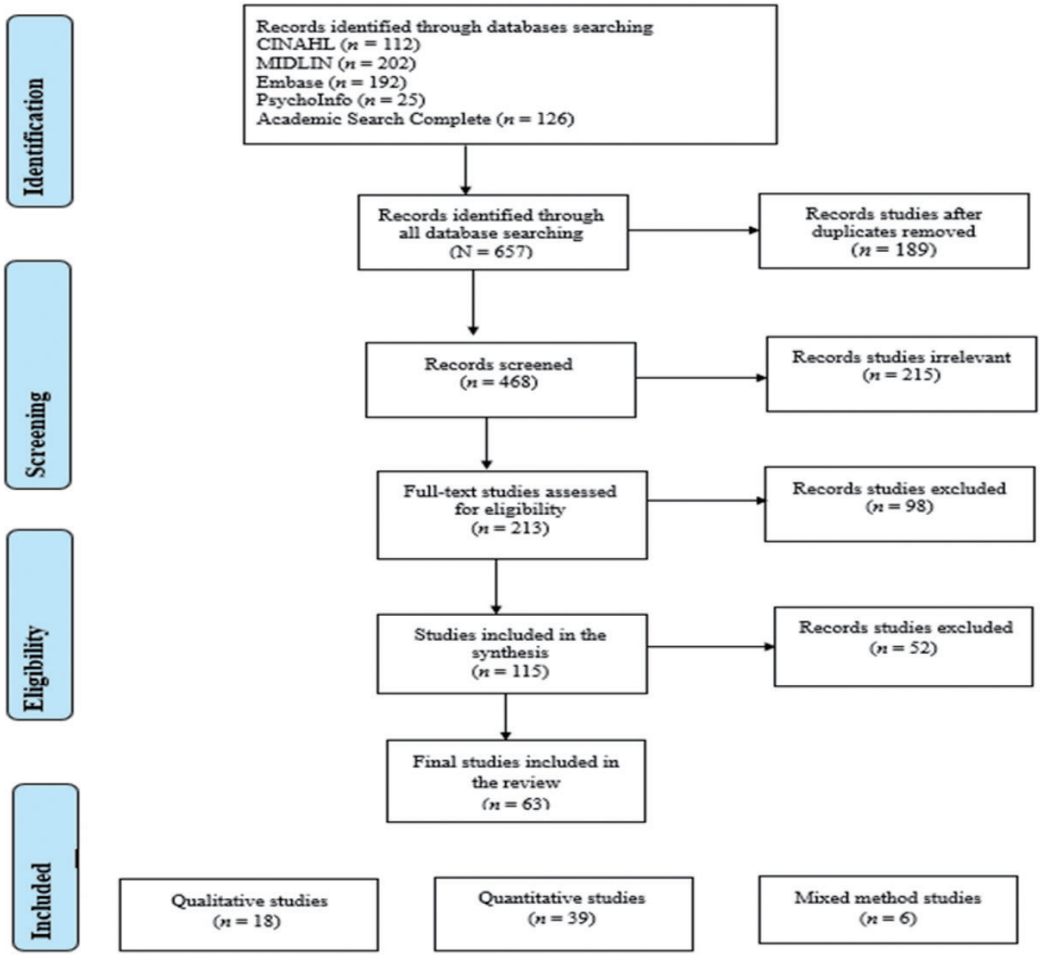

Figure 1. Literature search flow diagram

2.4 Data analysis

Data analysis in integrative reviews requires that the data are ordered, coded, categorized, and summarized into a unified and integrated conclusion.[16] Whittemore and Knafl's[15] analysis method involves data reduction, data display, data comparison, and conclusion drawing and verification. Data reduction for this review was accomplished using an extraction table to summarize and organize the data into factors and sub-categories. The data display stage using graphic representation enhances the visualization of patterns and relationships within and across primary data sources.[15] The factors impacting the use of FP are displayed in Figure 2. In the data comparison stage, emerging themes can be visualized in a conceptual model that includes most of the variables or identified themes.[15] This review's themes were organized using the social-ecological model (SEM; see Figure 3). The themes were organized into three levels of the SEM: personal domain (education, knowledge, and income), family and community domain (husband and family), and religious and cultural domain (religious beliefs and cultural norms). The conclusion drawing and verification phase allows subgroups to be integrated into a holistic portrayal.[15]

Figure 2. The factors impacting the use of family planning

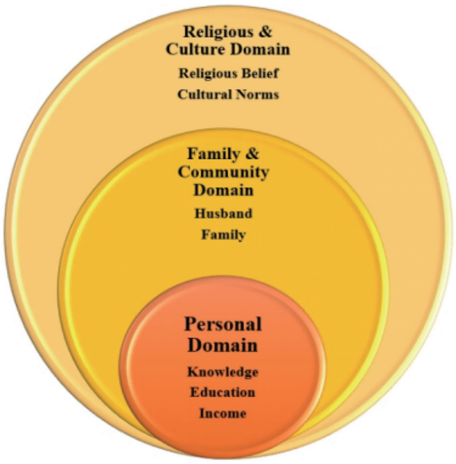

Figure 3. Factors that influence the use of family planning

3. Results

To support families in their decisions about FP, an integrative review of the literature was undertaken. The SEM was selected because it examines how individuals interact with their environment, examines how this interaction affects individuals' health and wellness, and is an excellent structure to examine the relevant factors that impact FP.[17] This model has previously been used to understand how couples make decisions about FP.[18] For this review, the model was modified to include the personal, the family and community, and the religious and cultural domains. The results reflect the strong influence of Arabic and Muslim society in the Middle East and Africa.

3.1 Personal domain

The personal domain involves the impact of couples' education, knowledge, and income on their use of FP methods. Each of these factors influences beliefs and values, including attitudes toward contraception, understanding of the risks and benefits of various contraception methods, and level of comfort discussing FP with partners.[19]

3.1.1 *Education*

Twenty-six of the 63 studies reviewed reported that education was a key factor influencing FP. Two studies conducted in Jordan reported a relationship between higher levels of education and increased engagement in FP and the use of contraception.[20,21] Alomair et al.[18] found that Muslim women in the Kingdom of Saudi Arabia had little to no education and were mostly unaware of FP. Arbab et al.[10] indicated in their study conducted in Qatar that more illiterate women (12.0%) and primary school-educated women (21.5%) were opposed to contraception in comparison to women with secondary school education (5.6%) or college education (14.8%; p = .001).

Alkindi and Alsumri[22] found that women and their husbands' levels of education were positively associated with the use of contraceptive methods for both women (p = .045) and their husbands (p = .048). Rahman et al.[23] also found that a higher education level for women and their husbands significantly increased their future use of contraception (OR = 1.67, 95% CI: 1.30–2.16; OR = 1.33, 95% CI: 1.03–1.71 respectively).

The importance of educating men cannot be underestimated. Three studies in Africa support the finding that educating men about FP results in men supporting women to use contraceptives.[24–26] Dikmen et al.[27] reported that the educational status of partners or husbands and refugee Syrian women in Turkey was significantly associated (p = .001) with FP. Authors across multiple countries including India, Pakistan,

the USA, and Iran have reported the positive influence of education on the uptake of FP.[28,29] However, the evidence is inconclusive; two studies included in this review did not report significant findings regarding education-influenced FP in Palestine[30] and Sri Lanka.[31]

3.1.2 *Knowledge*

The impact of a couple's knowledge about and understanding of FP differed in the included literature. Three studies in India explored how couples' knowledge of FP positively affects their decisions.[28,32,33] Gogoi et al.[34] found that both the Assamese Caste Hindu (98%) and Muslim (95%) respondents had very high levels of knowledge about FP. In contrast, Fatma and Kumar[35] and Alomair et al.[18] reported that many Muslim women lack basic reproductive knowledge and inadequate knowledge about contraception. Patra and Sing[32] reported in their study of Muslim women in India that 21% of women could not use contraception because they lacked or had incorrect knowledge of specific methods and sources. Similarly, 68% of respondents in Khalil et al.'s[36] study in the KSA were unaware of where to obtain contraceptives and 59.5% were unaware of the various contraceptive methods. Ibrar et al.[37] reported that 26.25% of the public in Pakistan was unaware of the effects of unplanned and repeated pregnancies.

Knowledge about FP in developing countries can significantly impact couples' use of contraceptive methods. According to Price et al.,[38] Syrian refugees have inadequate knowledge of reproductive health issues and frequently admit to not taking birth control. Elfstrom and Stephenson[39] reported that women were more likely to use contraceptive methods in communities where awareness of reproductive health was more prevalent: Niger (OR 2.12 [1.35, 3.32]), Guinea (OR 1.89 [1.04, 3.45]), and Zimbabwe (OR 1.55 [1.03, 2.34]). Somalian women said that the main predictive factors for contraceptives were a positive attitude toward contraceptives ($p = .01$) and knowledge of contraceptives ($p = .017$).[40] Abdulahi et al.[41] further showed that modern contraception was used by Somalian women with higher levels of knowledge and access to health services.

3.1.3 *Income*

Studies have shown that income influences the use of contraception. Hosany and Hamilton[42] reported that economic stability often determines when and how many children a family decides to have. People with higher incomes are more likely to use contraceptives.[31,43,44] Alkindi and Alsumri[22] stated that contraception use increased significantly with high monthly income ($p < .005$) and income level of a country. Pallangyo et al.[26] also reported a higher use of modern FP methods in high-income countries versus a lower use in low and middle-income countries. Elfstrom and Stephenson[39] highlighted that contraception was associated with wealth in both Egypt and Mali ($p = .05$), but the impact size was small. Given their broad confidence intervals, this finding must be reviewed with caution.[39] In addition, Saelim et al.[45] reported that economic difficulties strongly affected birth spacing. Conversely, Ahmed et al.[40] and Tarar et al.[46] did not report differences in FP due to income level.

3.2 Family and community domain

Couples' decisions about FP may be influenced by their relationship dynamics and social networks, such as family, friends, and healthcare providers. This includes how they communicate with each other about FP, negotiate decisions, and support each other in making decisions. Social networks can provide information, support, and resources that can help couples make informed decisions about FP. The family and community domain includes the influence of the husband as well as the family which can significantly impact a woman's decision making regarding reproductive health and FP.

3.2.1 *Husband*

In many countries, particularly in Arabic and Islamic societies, the husband's opinion plays an important role in FP decisions influencing whether contraception is used[30,47,48] and the type of contraception that will be used.[20] According to Sundararajan et al.,[49] men are thought to oversee decisions about FP's acceptability in the household. Five studies have reported that the primary reason women do not utilize contraceptives is their husbands' opposition.[32,36,37,50,51] Participants (48.76%) in Khan et al.'s[50] study in Bangladesh reported that the main reason for not practicing FP was their husbands' disapproval. Similarly, 10% of respondents in Ibrar et al.'s[37] study of Pakistani men and women thought that men's rigid behavior was the primary reason for not following birth spacing. Additionally, 28.75% of their respondents reported that male dominance prevented women from opting for birth spacing. Cift et al.[51] noted that 31% of their participants did not use birth control because the husband was the one who made the final decision regarding contraception. Raja Ariffin et al.,[48] in a comparative study of Muslim women from Malaysia, Iran, and the USA, found that husbands made decisions about contraceptive methods in approximately 91.8%, 74.5%, and 30.5% of cases respectively. Almost 44.2% of the US respondents said their husbands significantly influenced their choice of contraception, while 2.6% of Malaysian respondents, 16.6% of Iranian respondents, and 20.3% of American respondents made their own contraceptive decisions.[48]

Research has shown that women are more likely to use FP when they have an empowered husband who supports their

decisions and shares responsibility in the family.[52] Conversely, women who feel their husbands have strong traditional views and beliefs on family matters may feel less capable or less willing to use FP.[52] Almalik et al.[20] noted that women whose husbands had a desire for a few children use modern contraceptives rather than traditional contraceptive methods such as withdrawal (33.7% vs 8.2%). In contrast, women in their study whose husbands had a desire for more children were significantly more likely to use traditional contraceptives (34.2% vs 11.5%; $p = .002$). Bottcher et al.[53] surveyed women in Gaza, Palestine to learn who made the choices about contraception use. These researchers found that 41.2% of husbands made the decision, 33.3% of couples made the decision jointly, and 11.8% of women's contraception decisions were made by medical staff. Ocak and Ozmen[54] reported that males (93.46%) are less likely than females (66.67%) to believe that FP is necessary. Men play a significant role in crucial decisions that have an impact on women's reproductive health. Packer et al.[55] reported that engaging men in discussions about family size and contraceptive use with their spouses may be an effective starting point for encouraging male support for and use of contraception. Thus, couples need to discuss their views on FP and make sure that everyone's opinion is being heard, allowing for a more informed decision-making process.[56] It is also important to involve husbands in FP counseling because husbands are the influence of the family and community.

3.2.2 *Family*

The family structure and dynamics within the family also influence FP. According to Doner and Sahin,[57] a major factor preventing FP in Syria is men's freedom to legally marry up to four women, leading to women having many children due to a fear of polygamy. Women's decisions to have many children are also related to the relevance of having a son to families. In Ibrar et al.'s[37] study, respondents (21.25%) stated that families repeatedly attempted to conceive a male child. Abdi et al.[6] also reported that women's decisions to have many children were influenced by the pride a husband felt with a male child. Elmusharaf et al.[58] stated that families in South Sudan are under pressure during wars to have more children to make up for the deaths of men and children. Thus, the size of a family is considered a national obligation.

3.3 Religious and cultural domains

Religion and culture also influence FP decisions. This influence can be seen in the availability of FP services and resources as well as couples' attitudes and beliefs about FP. Religious beliefs and cultural norms all play a role in how couples plan their families. This is clearly evident in studies comparing Muslim, non-Muslim, Arabic, and non-Arabic populations in the Middle East and Africa.

3.3.1 *Religious beliefs*

Religious beliefs can have a significant impact on FP. Most religions are strict in their use of birth control and contraceptives.[59] Patra and Sing[32] stated that religious and cultural norms regarding contraceptives significantly impact the use of FP services. A study conducted in Sudan by Ocak and Ozmen[54] found that a majority (95.12%) of people who do not believe in FP identified their religious beliefs as the reason. Dal and Beydag[60] reported that all religions promote the reproduction of families. Conversely, Patra and Sing[32] found that non-Muslim women are significantly more likely than Muslim women to plan to use FP methods in the future (OR = 1.540, $p < .001$). Lasong et al.[61] reported that contraceptive use was less common among African traditionalist, Muslim, and Protestant women (AOR = 0.77; $p \leq .007$) than among Catholic women in Zambia. Tigabu et al.[62] discovered that all Ethiopian mothers were under religious pressure not to use modern contraceptives, regardless of their religion. However, Muslims in their study were 65% less likely than Orthodox Christians to use the FP services available to them (AOR = .35, 95% CI: .21,.60). The remaining religious groups in their study (Protestants, Catholics, and others) showed no significant relationship. Another study conducted in Nigeria found that Muslim women were less likely than Catholic women to use contraception.[63] Rahman et al.[23] found Muslim women in Bangladesh to be less likely than women of other religions to use modern contraception (OR = 0.74, 95% CI: 0.63–0.87).

This lower use of FP among Muslim women can be because Muslims believe that it goes against Allah's plan if families where both parents are present do not have children.[61] Ibrar et al.[37] reported that 38.75% of their respondents perceived birth spacing as being prohibited by Islam. Cift et al.[51] stated that 40% of Syrian refugees in Turkey claimed that their refusal to use birth control was influenced by their religious convictions. Khan et al.[50] reported that Rohingya people incorrectly believed that Islam forbids women from using contraceptives. Khalil et al.[36] found that women (42.7%) in their study did not use any method of FP because they believed religion forbade contraception. One of the controls on women's fertility found by Doner and Sahin[57] was the belief that Allah supervises the number of children, which was reported by their participants as preventing FP. Participants in Kane et al.'s[64] study pointed out that one could not decide how many children one should have because childbearing was God's will. Similarly, Cox et al.[63] reported that religion was the main reason many Somali participants did not discuss the number of children with their spouses. They would like to have these discussions, but some

specifically said that Allah determines the number of children a couple will have. Many women cite the common belief among Muslims that Islam values a high level of fertility as their reason for wanting more children and not using any form of contraception.[18]

Muslims trust the Quran and *Sunnah* [the way of Prophet Muhammad] for guidance in their daily lives.[18] Scholars and clergy who specialize in Islamic law say that pregnancy prevention is not against Sharia in Islam.[65] However, conflicting views and interpretations of what is written in the Sunnah exist when it comes to FP. Alomair et al.[18] reported that some Muslim women were willing to use contraceptives. Although 77% of women agree that contraception does not violate the Islamic faith, it is commonly believed that it does.[35] Fatma and Kumar's[35] participants (23%) reported that Islam is a religion that supports birth control but only when the mother is ill or unhealthy and feeding a baby. Shabaik et al.[66] noted that more than 80% of those who responded thought their religion approved of using contraception to avoid pregnancy and for medical purposes. Abdi et al.[6] indicated that many Muslim scholars and leaders in Wajir and Lamu in Kenya agree that FP is accepted in Islam. They accept it within the marriage and, more particularly, help determine the timing and spacing of pregnancies. However, many participants in Gele et al.'s[47] study reported that they had asked religious leaders about the use of contraception and were told to respect the natural order established by Allah in not using contraception. The opportunities to provide knowledge about FP include community health workshops led by trained professionals including religious scholars, Friday Mosque sermons, and/or religious study groups supported by Imams.[67]

3.3.2 *Cultural norms*

Culture can greatly influence the attitudes, beliefs, and behaviors associated with FP. Culture comprises a set of shared ideas and perceptions about social norms, behaviors, and values transmitted from one generation to another through teaching, modeling, and language.[68] Zhang et al.[29] reported that female Somali refugees in the US said that their beliefs about family size and contraception were strongly influenced by culture and religion. Kane et al.[64] stated that women in South Sudan are subjected to social pressure to have children and failing to do so results in social rejection or even ostracism. Within the Jordanian culture, women's reproductive decisions are in the hands of their husbands.[20] Almalik et al.[20] reported that husbands' desire for children influenced their choice of contraceptive methods. Doner and Sahin[57] found that sons were more important in Syrian culture because it is believed that boys support the family and carry the family's surname. Therefore, most families in their study continued to have children until they had sons. According to a study conducted by Usta et al.,[69] a 40% prevalence of contraceptive use among Syrian refugees in Lebanon reflects the influence of culture on the decision to use contraception. Contraception use in Syria is slightly lower than the international average, which was 47% among married women of reproductive age before the 2011 war began.

4. Discussion

4.1 Personal domain

The results of this integrative review show that couples' lack of knowledge about or unawareness of FP is a significant barrier to its use. FP requires both the husband and wife to understand their respective roles and responsibilities and know the different methods available. Each partner's knowledge about FP can greatly impact decisions about its use. Couples need to understand the importance of FP to make informed decisions and ensure the health and well-being of their family. These findings were supported by Guracho et al.[70] who stated that women with comprehensive knowledge of FP were two times more likely to have decision-making power about the use of FP than women with a lack of knowledge. The findings of this review also revealed that couples who are educated have better access to information related to FP. They are more likely to use contraceptives and have informed discussions about their reproductive health. Alsheyab et al.[71] also found that contraception use is more likely when a husband or wife has a high level of education. Likewise, Guracho et al.[70] showed that women with secondary level and higher education were about 11 times more likely to make decisions about FP use than those who are illiterate; women with elementary level education were about seven times more likely to decide to use FP than illiterate women.

4.2 Family and community domain

This review found that the husband is the most important familial factor influencing the uptake of FP by Arabic and/or Muslim couples. The husband is considered to have the authority to accept or reject FP. Men are less likely to use FP than women. This finding is supported by Bhatt et al.[72] who found that almost all married men and women in their study said that males made family decisions. These researchers also found that decisions about contraception are made by the husband or, more specifically, he decides whether his wife can use it or not. Additionally, Truong et al.[73] stated that most FP decisions are made by male partners, usually with the guidance of their mothers. If the husbands or mothers-in-law perceive the healthcare providers do not respect their religious beliefs, lack of trust may arise, and therefore they

refuse medical advice related to FP. Furthermore, some families may refuse to allow a woman to be examined by a male doctor or male nurse, thus reducing her access to FP services. These findings demonstrate the stature of the husband within the family structure and the influence of the mother-in-law.

4.3 Religious and cultural domain

Religious and cultural teachings were found to impact FP. Contraception is generally permitted in Islam, but there are varying opinions on which methods are acceptable and which application to use. Some Christian denominations were found to prohibit the use of artificial birth control, while others allowed it but only under certain circumstances. Muslims, Protestants, and African traditionalists were less likely than Catholics to use contraception.

Birth spacing was found to be accepted in Islam to improve the quality of life for mothers and their children. The Quran recommends that the mother should feed her baby for two complete years. This finding is supported by Egeh et al.[74] who stated that Islam accepts birth spacing, breastfeeding as a way of spacing, and the use of contraception that does not impair the health of the mother or her child. However, Egeh et al.[74] noted that contraceptive use to reduce the number of children is regarded as going against Islamic teachings. In some cultures, having many children is seen as a sign of status and wealth, while in others, smaller families are preferred for economic reasons. Big family size and preference for a son are vital characteristics of Arabic culture because boys support the family and carry the family's surname. These findings are supported by Elmusharaf et al.[58] who stated that big family size is essential to developing a sense of community. These authors noted that this development is strengthened by the presence of various helpful social networks, such as family, friends, neighbors, tribal leaders, and local artisans. Religious beliefs and culture highly influence FP decision making by the family unit (husband, mother-in law, and the woman). While the mother-in-law does influence the husband's decisions, the predominant discussion in the literature is the influence of the husband on FP decisions. The literature lacks discussion about how husbands or mothers-in-law perceive health providers based on their religious beliefs and the resulting impact on family planning.

4.4 Strengths and limitations

This integrative review has both strengths and limitations. The main strength of this review is that it is the first integrative review in Qatar to focus on the factors that influence contraception use and the demand for FP among couples. This review can inform the development of this region's FP programs and policies. Another strength is the systematic approach taken by two individuals in selecting evidence, assessing the quality of that evidence, and analyzing it following a theoretical framework, which resulted in a collection of rich and comprehensive data from peer-reviewed sources. The limitations of this review are related to the included studies. No recent studies have been conducted in Qatar. Additionally, most studies assessed the experiences or knowledge of only one member of each couple. No study addressed the barriers to FP for couples who are aware of or are knowledgeable about FP. It is also important to note that this review is primarily limited to the Middle East and Africa.

4.5 Implications for practice and recommendations

This review has several implications and recommendations. Healthcare providers must be aware of the factors impacting the use of FP to provide effective interventions. Dissemination of this review through various venues to health providers and engaging them in discussing potential practice changes will be important. Husbands are very influential in decision-making regarding the use of contraceptives but do not usually attend the clinics with their wives. They may not have the same access to accurate information about contraception. Leveraging media and technology, such as radio programs, short dramas, SMS, or WhatsApp messages, is one way to deliver information to the family, especially husbands, about FP. The presence of religious scholars in this messaging would be particularly important as they are held in high regard and are able to dispel myths and misunderstandings. Because religion strongly influences decision-making regarding FP services, education sessions, counseling, and media sources should understand and highlight the Quran in terms of contraception, birth spacing, and their benefits. Education and active engagement of male physicians in counseling husbands about FP's advantages may increase their presence at FP clinics. Education about the impact of education, knowledge, family, culture, and religion need to be integrated into current healthcare practices and health education programs for providers as well as be considered within school health programs. The school health programs can play a vital role in promoting knowledge around FP and general reproductive health, health and hygiene life skills, and decision making led by female health educators in girls' schools.[75] Women can also be educated at PHCC and maternal and child health clinics during antenatal and postnatal care sessions.[76] This education and FP counselling are mostly provided by female physicians or midwives to female patients. In some areas where male physicians are the only available providers, cultural sensitivity and privacy must be ensured. To improve the impact of this education, both husbands and wives should be included in FP counselling, especially in community settings.[76] In addition, further

research to learn about husbands' perceptions of FP is key to providing a comprehensive picture of family planning and development of interventions. Another important area of research to explore would be the intersectionality of the family's religious beliefs, health providers' understanding of these religious beliefs, and the family's perception of health providers' influence on FP knowledge and decisions.

5. Conclusion

This review aimed to identify the factors influencing couples' FP decisions. The findings identified seven key factors including knowledge, education, income, husband, family, religion, and culture. Understanding the factors influencing FP decisions is important when making informed decisions and providing effective interventions. Effective interventions to change individual behavior and/or system processes require the engagement of all relevant stakeholders, especially end users of the information. Barriers and facilitators to uptake and application of the information can be addressed by understanding the target audience through methods such as focus group discussions, surveys, or interviews. Couples could then be fully informed and the potential for change in behavior and health system processes and structure can be realized. Developing and implementing interventions to support FP uptake will require consideration from all stakeholders and champions who can serve as catalysts for change. Careful planning of implementation strategies and approaches will be important to the successful uptake of information, which has the potential to influence the health and well-being of mothers, children, and families.

Acknowledgements

I am grateful to PHCC in Qatar for giving me the opportunity to pursue a Master's degree at the University of Calgary in Qatar. The authors acknowledge graduate faculty members at the University of Calgary in Qatar for their support during our study journey.

Authors contributions

JHA was responsible for researching literature, gathering, analyzing the data, interpreting the results and writing. Dr. DW project supervisor and mentor. DF made substantial contributions to the design, drafting, and revision of the manuscript. SA made valuable contributions to the design and execution of searches. All authors read and approved of the final manuscript.

Funding

No funding was received for this research.

Conflicts of Interest Disclosure

The authors declare that there is no conflict of interest.

Informed consent

Obtained.

Ethics approval

The Publication Ethics Committee of the Association for Health Sciences and Education. The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

Provenance and peer review

Not commissioned; externally double-blind peer reviewed.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Data sharing statement

No additional data are available.

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