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SOCIAL NORMS INFORMING CONTRACEPTIVE USE AMONG WOMEN LIVING WITH HIV IN ILALA DISTRICT, DAR ES SALAAM, TANZANIA

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ABSTRACT

Background: Women Living with HIV (WLHIV) make contraceptive choices within complex social contexts shaped by relational and community norms. The study aimed to examine how social norms influence contraceptive use decisions among WLHIV in the Ilala District, Dar es Salaam, Tanzania.

Methods: A cross-sectional qualitative study was conducted from May to June 2025 among 15 women of reproductive age living with HIV who attended Care and Treatment Clinics in Ilala District, Dar es Salaam, Tanzania. Data were collected through in-depth interviews, and participants were purposively selected using maximum variation sampling. Interviews were audio-recorded, transcribed verbatim, and analyzed inductively using NVIVO 14. Ethical approval was obtained, and all participants provided written informed consent.

Results: Fifteen WLHIV, aged 19–42, participated in the study. Most were married, with primary or secondary education, and engaged in various livelihoods. Contraceptive decisions were influenced by social norms from interpersonal, relational, and community levels. Gender roles limited reproductive autonomy and led to covert use. Peer networks provided both misinformation and support. Community stigma and family silence reinforced secrecy and restricted open discussion. Some women reported supportive partners, peers, and healthcare providers who aided open decision-making. Secrecy was a common, but not universal, strategy to manage social expectations about fertility, sexuality, and HIV.

Conclusion: Contraceptive decision-making among WLHIV is shaped by social and relational factors beyond access to services. Supporting reproductive autonomy requires addressing stigma, communication, and social relationships. More research across diverse settings is needed to understand how these factors affect reproductive experiences.

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INTRODUCTION

Over the past two decades, global contraceptive use has risen, with an estimated 1.1 billion women in need of family planning and about 874 million using modern methods.¹ Despite this progress, a substantial unmet need remains, particularly in low- and middle-income countries, where many women who wish to avoid pregnancy still lack access to adequate services.² Sub-Saharan Africa continues to have lower levels of modern contraceptive use and persistent disparities in access and quality of care, especially among adolescents and young women.³ Women living with HIV (WLHIV) face intersecting challenges that further constrain access to and use of contraception. These include stigma, gender inequality, fragmented service delivery, and structural barriers that limit reproductive autonomy.^{4,5} Although integrating HIV and family planning services has improved service availability, evidence suggests that increased access alone does not necessarily translate into informed, voluntary, or sustained contraceptive use among WLHIV.^{4,6} This suggests that factors beyond service availability continue to influence contraceptive decision-making among WLHIV.

In Tanzania, modern contraceptive use among WLHIV remains suboptimal despite the expansion of reproductive health and HIV services. Recent evidence from Ilala Municipality indicates that contraceptive prevalence among women is approximately 37-39%, with lower uptake among WLHIV due to persistent social and structural barriers.^{7,8} These gaps between service availability and actual utilization underscore the need to better understand the contextual factors that influence contraceptive decision-making among WLHIV. Consequently, Ilala Municipality provides an ideal setting to examine how social environments shape contraceptive use decisions among women living with HIV.

Social norms play a central role in shaping reproductive behavior, including contraceptive use. These norms operate through shared expectations within social relationships and communities, shaping what individuals perceive as acceptable or typical behavior.^{9,10} In many settings, reproductive decisions are shaped not only by individual preferences or access to services but also by perceived approval from partners, families, and communities. However, restrictive gender norms, male partner expectations, and moral judgments

continue to constrain women's reproductive autonomy and contraceptive decision-making.⁹⁻¹¹ These dynamics are best understood through Social Norms Theory¹², which explains how perceived social expectations and approval within reference groups influence individual behavior.

For WLHIV, these normative pressures are intensified by HIV-related stigma and conflicting expectations about childbearing, sexuality, and responsibility. Women are often expected to demonstrate responsible reproductive behavior while also being judged for limiting or spacing childbearing.¹³⁻¹⁵ These intersecting norms shape contraceptive decisions at multiple levels, including intimate partnerships, peer networks, family structures, and broader community environments. Despite this complexity, limited attention has been paid to how WLHIV experience and negotiate these norms in their everyday lives.

Existing research on contraceptive use among WLHIV has largely relied on quantitative approaches, which offer limited insight into how women interpret, resist, or conform to prevailing social expectations.¹⁶⁻¹⁸ As a result, qualitative evidence remains insufficient to explain how social norms are enacted through interpersonal relationships and how they shape contraceptive autonomy in lived contexts. This gap limits the development of interventions that address not only service delivery but also the social environments in which reproductive decisions are made.

Therefore, the study aimed to examine how social norms across intimate partner relationships, peer networks, families, and communities influence contraceptive use decision-making among women living with HIV in Ilala District, Dar es Salaam. Understanding these dynamics is essential for informing interventions that strengthen reproductive autonomy, reduce stigma, and improve contraceptive outcomes for WLHIV.

METHODS

STUDY DESIGN AND SETTING

This study used a cross-sectional, qualitative, exploratory design to examine how social norms influence modern contraceptive use among women living with HIV. Data were collected at a single point in time through qualitative methods to capture detailed, context-rich insights into participants' experiences, perceptions, and decision-making regarding contraception.¹⁹ This approach is well-suited to exploring complex social and cultural

Table 1: Characteristics of the Study Participants

IDN O	Age	Marital Status	Parity	Education	Occupation	Contraceptive use	Years LWHIV
P01	22	Single	1	Form IV	Petty trader	Yes	4
P02	32	Married	1	Form IV	Petty trader	Yes	7
P03	41	Married	2	Standard 4	Petty trader	Yes	8
P04	42	Married	1	Standard 4	Self-Employed	Yes	6
P05	40	Single	2	College	Self-Employed	Yes	5
P06	20	Single	0	Diploma	Student	Yes	3
P07	27	Partnered	0	Diploma	Unemployed	Yes	5
P08	22	Single	1	Certificate	cameraperson	Yes	3
P09	36	Married	3	Standard 7	Petty trader	Yes	6
P10	19	Single	0	Standard 7	Unemployed	Yes	2
P11	27	Partnered	2	Form II	Unemployed	Yes	7
P12	27	Partnered	2	Form IV	Petty trader	Yes	5
P13	32	Married	1	Form IV	Petty trader	Yes	8
P14	24	Married	2	Form IV	Petty trader	Yes	4
P15	42	Married	3	Form IV	Employed	Yes	11

factors that are not easily captured by quantitative measures.²⁰ The study was informed by Social Norms Theory¹² which informed the exploration of how perceived expectations from partners, families, peers, and communities shape contraceptive decision-making among women living with HIV.

The study was conducted in Ilala District, Dar es Salaam Region, Tanzania, from May to June 2025. According to the 2022 national census, Ilala has a population of 1,649,912, comprising 793,731 males and 856,181 females.²¹ Dar es Salaam, located on Tanzania's eastern coast, is administratively divided into five districts: Kinondoni, Ilala, Temeke, Ubungo, and Kigamboni. Ilala has a well-established health infrastructure, including referral hospitals, Care and Treatment Centers (CTCs), health centers, and dispensaries that provide integrated HIV and reproductive health services.⁷

STUDY POPULATION AND SAMPLING

The study population comprised women of reproductive age (15–49 years) living with HIV who attended Care and Treatment Clinics in Ilala District, Dar es Salaam. Fifteen women were purposively selected for their relevance to the study objectives and their lived experiences with contraceptive decision-making. Participants were identified and recruited in collaboration with healthcare providers at the selected clinics and approached based on their willingness to participate. Written informed consent was obtained before data collection. Sampling continued until data saturation was achieved,

defined as the point at which no new themes or insights emerged from successive interviews. A purposive maximum-variation sampling approach was used to ensure inclusion of participants with diverse characteristics relevant to contraceptive decision-making, including age, marital status, parity, educational level, and socioeconomic background.

DATA COLLECTION

Data were collected through in-depth interviews (IDIs) using a semi-structured interview guide informed by existing literature and theoretical frameworks on social norms and reproductive decision-making. The guide covered key domains, including partner and family influence on contraceptive use, peer and social network influences, experiences of stigma and community judgment, communication about contraception, and decision-making processes.

The interview guide was developed in English and translated into Kiswahili to ensure cultural relevance and clarity. Data collection was conducted by the first author, with assistance from a trained research assistant experienced in qualitative research and in working with vulnerable populations. Interviews were conducted face-to-face in a private, quiet space within the health facility to ensure confidentiality and promote open dialogue.

Participants were identified and approached in collaboration with healthcare providers at the selected clinics. Those who provided written

informed consent participated in the interviews. All interviews were audio-recorded with permission and assigned unique identification codes. Field notes captured nonverbal cues and contextual information. Probing and follow-up questions were used to explore emerging issues in greater depth. Each interview lasted 45–60 minutes.

DATA ANALYSIS

All interviews were transcribed verbatim within 48 hours and then cross-checked against the audio recordings for accuracy. Identifying information was removed before the transcripts were imported into NVivo 14 for data management. An inductive thematic analysis was conducted using Braun and Clarke's six-step framework²² a reflexive thematic analysis approach. Transcripts were read repeatedly to ensure familiarity with the data, followed by systematic line-by-line coding to identify meaningful segments.

Coding was led by the first author, with regular discussions among the research team to compare interpretations and resolve discrepancies, thereby strengthening analytical credibility. Related codes were grouped into preliminary themes and iteratively reviewed and refined to build a coherent thematic structure.

Data collection and analysis were conducted concurrently, allowing emerging insights to inform subsequent interviews. An audit trail of analytical decisions was maintained, and reflexive notes documented evolving interpretations and the researcher's assumptions. Peer debriefing was conducted to enhance interpretive rigor. Illustrative quotations are presented in the findings to support the identified themes.

REFLEXIVITY AND POSITIONALITY

Both authors are public health researchers trained in sexual and reproductive health and HIV-related research. This background may have influenced the study design, data collection, and interpretation of findings. To minimize potential bias, the researchers engaged in continuous reflexive practice through memo writing and regular discussions throughout data collection and analysis. A non-judgmental approach was maintained during interviews to encourage open responses, and participants' perspectives were prioritized throughout the analysis.

ETHICAL CONSIDERATION

The study received ethical approval from the Institutional Review Board of Muhimbili University

of Health and Allied Sciences (MUHAS-REC-05-2025-2909). Authorization to conduct the study at the CTC clinics was obtained from the Ilala District administration. Participation was voluntary, and all participants provided written informed consent before data collection. Participants were informed of their right to decline participation or withdraw from the study at any time without losing access to healthcare services. No personally identifiable information was collected, and all data were anonymized and securely stored, with access limited to the research team. The study adhered to the ethical principles outlined in the Declaration of Helsinki.

RESULTS

The study included 15 women living with HIV, aged 19 to 42 years. Most were married; some were single or in partnerships. Education levels ranged from primary to secondary, with a few having post-secondary education. Petty trading was the most common occupation; others were unemployed, self-employed, students, or employed. All used contraception. HIV duration ranged from 2 to 11 years. Parity varied among participants. Detailed characteristics of the study participants are presented in Table 1.

The analysis revealed that social norms shaped contraceptive decision-making among women living with HIV (WLHIV) across relational, peer, family, and community contexts. Participants' experiences were not uniform; while many described barriers, stigma, and limited support related to contraception, others reported supportive environments that facilitated contraceptive use and open communication with partners and health care providers.

PARTNER INFLUENCE: GENDERED NORMS AND REPRODUCTIVE CONTROL

Partner relationships were central spaces where contraceptive decisions were negotiated, contested, or concealed. Many participants described male partners as influential in shaping reproductive expectations, often mirroring broader norms that link fertility to femininity, marital stability, and trust.

"When I told my husband I wanted family planning, he got very angry. He said, 'If you do that, don't expect another child from me.' He believes it destroys the womb... so I went secretly for an injection. He doesn't know..." (IDIP03)

This account shows that contraceptive use was sometimes seen as a challenge to male authority and reproductive expectations. However, not all women

faced resistance. A few participants reported having supportive partners who encouraged contraceptive use and shared in decision-making.

“He told me it’s better to plan our children. He even reminds me when it’s time for the injection.” (IDIP12)

These contrasting experiences suggest that partner influence is not uniform but is shaped by differing interpretations of masculinity, fertility, and trust in relationships.

In some cases, resistance was linked to fear of infertility or misinformation, which shaped emotional responses and influenced control over reproductive decisions.

PEERS’ INFLUENCE: INFORMATION, MISINFORMATION, AND SOCIAL LEARNING

Peers played a dual role in shaping perceptions of contraception. Some participants reported that peers spread fears about infertility or side effects, while others offered encouragement and accurate information.

“People kept saying contraceptives cause infertility...I was afraid at first.” (IDIP01)

In contrast, supportive peer relationships helped some women reassess these fears.

“A friend who is a nurse explained everything to me properly. I trusted her, so I decided to try.” (IDIP05)

These accounts indicate that peer networks can serve as both reinforcing and challenging environments for social norms, depending on the credibility and trust within relationships.

COMMUNITY PERCEPTIONS AND STIGMA: NORM ENFORCEMENT THROUGH JUDGMENT.

At the community level, contraceptive use, particularly among young or unmarried women living with HIV, was often met with moral judgment and stigma. Participants described how their decisions to use contraception were shaped by fear of gossip, scrutiny, and being labeled promiscuous or irresponsible.

“People would stare and say, ‘Why is she always going to the family planning clinic?’ That’s why I go far away.” (IDIP08)

Some women reported feeling constantly observed and judged by others in their communities.

“I feel people are watching me... even when I just pass near the clinic, I feel judged.” (IDIP10)

These experiences led some participants to conceal their contraceptive use or travel outside their communities to avoid being recognized.

However, a few women reported neutral or supportive community environments where stigma was less pronounced, suggesting variability in how community norms are enforced.

FAMILY SILENCE: ABSENCE OF DIALOGUE AS A SOCIAL NORM

Family communication about contraception was largely constrained by cultural taboos and hierarchical relationships. Many participants reported discomfort or an inability to discuss reproductive matters with their families.

“In my family, it is shameful to talk about such things... so I just keep quiet.” (IDIP01)

This silence was not only an absence of communication but also a social norm that governed what could be discussed regarding sexuality and reproduction.

Some participants described the emotional consequences of this silence:

“It’s hard... you make such decisions alone. Sometimes I wish I had someone to talk to.” (IDIP06)

However, a few women reported being selectively open with trusted female relatives, indicating that family norms could be negotiated in some contexts

CROSS-CUTTING PATTERN: SECRECY AS A NEGOTIATED RESPONSE

Across partner, peer, family, and community contexts, secrecy emerged as a common strategy among women living with HIV to navigate competing social expectations and avoid social sanctions for contraceptive use.

“I don’t tell him... I just go quietly for the injection.” (IDIP07)

For some women, secrecy was described as stressful and emotionally burdensome, marked by fear of discovery and internal conflict.

“I feel guilty sometimes... but I have no choice.” (IDIP03)

However, not all participants relied on secrecy. Women with supportive partners or those who had nonjudgmental healthcare experiences reported more open contraceptive use and shared decision-making.

This variation highlights that secrecy is not an inevitable outcome but a context-dependent strategy shaped by relational and social conditions.

HIV SPECIFIC NORMATIVE PRESSURES

Participants' accounts also reflected the influence of HIV-related stigma on reproductive decision-making. Some women described feeling pressured to demonstrate "responsible" reproductive behavior while avoiding judgment regarding sexuality or childbearing decisions.

"People think that because you have HIV, you should not have more children or plan pregnancy at all." (IDIP11)

These narratives suggest that WLHIV navigate layered normative expectations, and reproductive decisions are evaluated through both gendered and HIV-related moral lenses.

DISCUSSION

This study examined how social norms across intimate relationships, peer networks, families, and communities shape contraceptive decision-making among women living with HIV in Ilala District. The findings show that contraceptive use is not solely an individual health decision but a socially negotiated practice shaped by gendered expectations, normative sanctions, and HIV-related stigma. Across these domains, women navigated competing expectations about fertility, morality, partnership, and responsible reproduction. Secrecy emerged as a common, though not universal, strategy for managing these tensions.

The study's findings align with existing research, highlighting partners' crucial role in shaping contraceptive use through gendered power dynamics.^{23,24} When male partners control reproductive decisions or reinforce fears about contraceptives (such as infertility), women's autonomy is constrained.^{23,25} As a result, women often resort to covert use to manage relationship expectations. Recent studies from Uganda^{25,26} and other settings²⁷⁻²⁹ show that contraceptive decision-making is often negotiated within patriarchal expectations regarding fertility, relationship stability, and ideal family size. In many Sub-Saharan African contexts, these expectations frequently outweigh women's individual reproductive preferences, influencing whether contraceptives are adopted, when they are used, and which methods are chosen.^{11,13,30}

The findings further suggest that partner influence operated not only through interpersonal dynamics but also through injunctive gender norms that cast men as legitimate authorities in reproductive decision-making. Women's narratives reflected

broader expectations that fertility and childbearing symbolize femininity, marital commitment, and social respectability. In this context, contraceptive use could be interpreted as resistance to expected reproductive roles, prompting some women to adopt covert contraceptive use as a negotiated form of constrained agency rather than open resistance. These findings align with broader evidence that women are more likely to use contraception when they perceive partner support, whereas partner opposition is linked to covert use or discontinuation.^{31,32} However, experiences were not uniformly restrictive. Some participants described supportive partners who encouraged contraceptive use and engaged in joint reproductive decision-making. These contrasting experiences suggest that gender norms are negotiated differently across relationships and may shift when couples have greater exposure to reproductive health information or communication support. These findings highlight the potential value of interventions that promote equitable communication and shared reproductive decision-making among couples.²⁵

Peer networks also shaped women's perceptions and decisions about contraception. Some participants described peers as sources of misinformation about infertility, side effects, or contraceptive risks, heightening uncertainty and fear.^{31,33,34} Conversely, trusted peers, particularly those with health knowledge or personal contraceptive experience, offered reassurance and practical guidance, increasing confidence in contraceptive use.^{32,35} Studies indicate that positive attitudes toward peers' contraceptive use are associated with higher usage rates, especially among young women, emphasizing the powerful role of communication in shaping contraceptive norms and behaviors.^{28,31,36} These findings suggest that peer networks are important sites for the circulation, reinforcement, and negotiation of social norms. Through everyday conversations and shared experiences, peers shaped women's perceptions of what reproductive behavior was acceptable, risky, or socially appropriate. At the same time, supportive peers sometimes disrupted prevailing misconceptions by legitimizing contraceptive use and offering alternative narratives grounded in trust and lived experience.

Building on peers' influence in shaping perceptions and providing social support, emotional encouragement, and informational guidance within

women's networks appeared to strengthen confidence in reproductive decision-making.^{27,32} These forms of support may help women navigate uncertainty, challenge misinformation, and reduce fears about contraception. The findings, therefore, suggest that peer relationships may serve not only as channels for transmitting restrictive norms but also as spaces for normative change and reproductive empowerment. At the community level, stigma and moral judgment remained significant barriers to contraceptive use, particularly for younger or unmarried WLHIV. Social norms that associate family planning with promiscuity or deviance from expected female roles heighten scrutiny and shame, discouraging open contraceptive use.^{4,7,25} Existing evidence also shows that community fertility ideals and negative attitudes toward contraception strongly shape contraceptive behavior.^{9,31} Community responses in this study reflected social control through gossip, social scrutiny, and anticipated judgment, reinforcing expectations about sexuality, fertility, and "appropriate" womanhood. These pressures were especially pronounced for women living with HIV, whose reproductive decisions were often evaluated against overlapping moral expectations tied to HIV status, motherhood, and sexual respectability. In response, some women avoided nearby clinics or concealed contraceptive use to manage anticipated social sanctions. Nevertheless, a few participants described less restrictive social environments or supportive interactions with healthcare providers that facilitated more open contraceptive use. These differing experiences suggest that community norms are neither static nor universally experienced, but instead vary across social contexts and relationships. Family silence on contraception, shaped by cultural taboos and hierarchical family structures, limited women's opportunities to seek guidance or emotional support. Similar findings have been reported elsewhere, where conversations about contraception within families are often

infrequent, incomplete, or avoided altogether, particularly between younger women and older relatives.^{16,27,37} Importantly, this silence was not merely an absence of discussion but a socially reproduced norm that regulated what could be discussed about sexuality and reproductive health. This silence reinforced the privatization of contraceptive decision-making and limited opportunities for intergenerational support or for correcting misinformation. However, a small number of participants reported selective openness with trusted female relatives, suggesting that family norms may also be negotiated through relational trust and shared reproductive experiences. Secrecy emerged as a recurring response across partner, peer, community, and family contexts as women navigated conflicting expectations while maintaining some reproductive control. Covert contraceptive use has been widely documented in sub-Saharan Africa and reflects the social costs of challenging dominant reproductive norms.^{38–40} In this study, secrecy served as both a protective and an adaptive strategy. While it enabled some women to exercise limited reproductive agency, it also reflected the constraints under which reproductive decisions were made. Women frequently described emotional burdens associated with secrecy, including fear, guilt, loneliness, and anxiety about discovery. These findings highlight how social norms may simultaneously shape behavior and define the social consequences of deviating from expected reproductive roles. Notably, HIV status appeared to intensify these reproductive negotiations. Participants described pressure to demonstrate "responsible" reproductive behavior while avoiding judgment about sexuality, fertility limitation, or childbearing decisions. This layered stigma illustrates how WLHIV navigate overlapping expectations regarding health, morality, and womanhood, making contraceptive decision-making particularly socially complex. The study's findings underscore that contraceptive autonomy among women living with HIV is shaped not only by access to services but also by broader

interpersonal and social dynamics. These dynamics suggest that strengthening supportive communication, reducing stigma, and fostering enabling social environments may be important for improving women's ability to make informed, autonomous reproductive decisions. Given the qualitative and context-specific nature of this study, the findings should be interpreted with caution. Several limitations should be noted. First, the cross-sectional design captures participants' experiences at a single point in time and does not account for changes in contraceptive decision-making over time. Second, although the study population comprised women living with HIV, recruitment from Care and Treatment Clinics may have introduced selection bias by excluding those not engaged in routine HIV care or those with limited access to health services. In addition, social desirability bias may have influenced participants' responses because discussions of HIV status, sexuality, and contraceptive use are sensitive. Despite efforts to ensure confidentiality and a nonjudgmental interview environment, participants may have provided responses perceived as socially acceptable. Furthermore, member checking was not conducted, which may limit participants' opportunities to validate or refine the findings. Nevertheless, the study provides important insights into how social norms shape contraceptive decision-making among women living with HIV in this setting. Further research across diverse contexts is needed to examine how social norms surrounding HIV, fertility, and contraception are negotiated across different social and cultural environments.

CONCLUSION

This study demonstrates that contraceptive decision-making among women living with HIV is shaped by intersecting social norms, gendered power relations, and stigma across intimate, familial, peer, and

community contexts. In this setting, contraceptive use is often negotiated in response to moral expectations regarding fertility, sexuality, and HIV, with some women resorting to secrecy to navigate competing social demands while preserving reproductive control.

Overall, the findings highlight that contraceptive autonomy extends beyond access to services and is strongly shaped by social and relational dynamics. Social norms regarding HIV, fertility, and contraception play a key role in how reproductive decisions are negotiated and experienced. Further research across diverse contexts is needed to deepen understanding of these processes.

AVAILABILITY OF DATA AND MATERIALS

All the necessary data and materials are within this manuscript.

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AUTHOR CONTRIBUTIONS

UM: Conceptualization, data collection, data analysis, interpretation, and manuscript drafting. EM: Participated in conceptualization, data analysis, and interpretation, and critically reviewed the manuscript. All authors read and approved the final manuscript for submission.

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COMPETING INTERESTS

No conflict of interest declared

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