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Barriers and perceptions regarding different contraceptives and family planning practices amongst men and women of reproductive age in rural Pakistan: a qualitative study

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Abstract

Background: Pakistan ranks as one of the most poorest and most populous in the world with poor reproductive health indicators. This study helps in understanding barriers and perceptions regarding Family Planning (FP), modern contraception, quality of care and free of charge FP services amongst men and women in rural Pakistan.

Methods: Employing purposive sampling and Focus Group Discussion (FGD) technique, this qualitative study was conducted with men and women of reproductive age in Pakistan. Atotal of eight FGDs were conducted in Sindh and Punjab provinces. Being descriptive in nature, the study provided a thematic analysis of the relevant health issues by using an adapted constant comparison analysis process.

Results: The contraceptive knowledge and uptake was low and misinformation was prevalent. Men thought of vasectomy as against men' pride and both males and females viewed removal of uterus as a permanent method. The women claimed neighbors, mother-in-law, friends and sister in-law and husband as main sources of information. Women seemed to have a greater exposure since they regularly come into contact with lady health workers and lady doctors but that information is not passed on to their husbands or discussed openly. There were many misconceptions prevalent among the participants, most of which were spread by untrained providers, such as the undesirable impact contraception can have on a woman's ability to conceive children. In addition, restrictions on female mobility and side effects were seen as barriers to contraception by majority of women whereas, most of the men perceived religio-cultural factors as barriers and considered FP as an additional expenditure.

Conclusions: Though importance of family planning was recognized by the participants for the well being of the children and financial benefits of raising fewer children but the wellbeing of the woman was not considered a meaningful goal to pursue FP. Besides access, barriers towards use included money, where frequency of use and choice of method was affected by financial limitation. Agendered perspective also prevailed with reference to provider seeking behavior. Spousal communication is a topic mostly neglected by family planning programs, yet many of the barriers are linked to it. There is a need to design health interventions that devise counseling techniques to improve spousal communication, debunk the myths and misinformation in the community, and link the health of the child and mother with birth spacing and smaller family size.

Keywords: Contraceptives; Family Planning; Reproductive health; Modern contraception; Pakistan.

Background

An estimated 215 million women in the developing world have an unmet need for modern contraception (1). The most recent nationally representative survey conducted in the country, the Pakistan Demographic Health Survey 2006-07 (PDHS) reveals the dire state of reproductive health indicators (2). The survey indicates that use of modern contraceptive methods among currently married women is 22%; whereas the use of contraception is even lower among rural residents (17.7%) and among women with low levels of education. Unmet need in Pakistan stands at 25% among currently married woman out of the 55% of married women that express the need to use contraceptives (the rural unmet need is 26.5% and women of the lowest wealth quintile has the highest unmet need which is 31%). The cited reasons for the unmet need are access and quality of services, barriers to cost and equity. Total need is 54.5%; for spacing it is 17.4% and for limiting is about 37.1% (2) an estimated 14 million married women demand for family planning. The total met need is 29.6%; met need for spacing is 6.5%, and for limiting it is 23.1%. The total unmet need is 24.9%; for spacing it is 10.9% and for limiting it is 14%. Meeting this demand can have immediate effect reducing Pakistan's Total Fertility Rate (TFR) to three births per woman thereby putting us on the trajectory for reaching replacement fertility in the near future according to Population Council. However, there has been a decline in the TFR, from 5.4 children per woman in 1990-91 to 4.1 children in 2006-07 - a drop of over one child in the past 16 years. However, TFR is much higher in women living in the rural areas; with no education and in the poorest group, i.e. 4.5, 4.8 and 5.8 respectively. The most popular methods of FP among women under age 30 are the condom, followed by withdrawal and the rhythm

method commonly known as traditional methods. Women in their early 30s tend to use condoms and sterilization, while among women in their late 30s and 40s, female sterilization is the most widely used method. Use of reliable modern methods for longer term spacing is still far from their potential in Pakistan.

With such poor reproductive health indicators, Pakistan ranks as one of the poorest and most populous countries in the world with approximately 177 million people (3). Where, 50% of the population is female and an estimated 28 million are married women of reproductive age (2). More than 25% of the population lives below the poverty line of less than $1 a day and another 60% are living below $ 2 a day (4). In addition, more than 73% of the population is not fully covered for health and seeks care by making out-of-pocket health expenditure (4). Moreover, 30% of the First Care Level Facilities (FCLF) such basic health units are non-operational (4). The cycle of poverty is exacerbated by high maternal mortality rates, with nearly 30,000 women dying annually in Pakistan due to complications arising from pregnancy or childbirth. Approximately 1 in 89 women in Pakistan will die of maternal causes during her lifetime (lifetime risk) (2). There is a lack of awareness of the importance of rights associated with health, in particular Sexual and Reproductive Health (SRH) by both men and women. As a result, access to quality SRH services and information remains limited (4).

While there is concentration of qualified doctors and trained nursing/ paramedic staff in big cities, indigenous providers (often with no formal training) provide the bulk of services in smaller towns. For reproductive health services, it is the female practitioners such as village dais (Traditional Birth Attendants), midwives, and nurse practitioners who are the providers of choice for women. Though there is a dire need for more trained health personnel in these underserved areas, program efforts geared towards improving access to reproductive health services cannot exclude the existing network of providers that have deep roots in the community. To address this gap especially among the poor and underserved, Marie Stopes Society (MSS) launched an innovative social franchising model ensuring accessibility of high quality and affordable FP and reproductive services and employed a voucherbased system for long-term family planning method i.e. Intra-uterine device (IUD). This franchise model, branded as SURAJ (the sun) was implemented in underserved and remote areas of 18 districts in Punjab and Sindh, through a partnership with 100 providers and 100 Field Worker Marketing (FWM). The model offers accessible and affordable quality FP services by training private providers and marketing and branding its products. MSS also introduced an Output-Based Aid (OBA) voucher scheme with a focus on promoting use of Intra-Uterine Contraceptive Device (IUCD).

The objectives of the present study was to conduct the need assessment in order to identify channels of service delivery and to familiarize the project team with important and local context-specific issues prevalent in the region. Secondly, it would supplement a larger quantitative private provider survey to be conducted at a later stage and emphasize on the issues that need to be further investigated in the quantitative study and to strengthen the quality of information, especially regarding the attitudinal and behavioral aspects of the respondents. Thus, the study took place before the private provider partnership was established and implemented. The specific themes covered in the focus groups were contraceptive use and trends, revealing local barriers, myths and misconceptions to contraceptive use, perceptions towards quality of services and free services before the service provision and voucher distribution. This study also extends previous research by examining contextualized trends in contraceptive use and identifying barriers, attitudes and perceptions towards quality of service with special reference to services that are free of cost. A greater understanding of these factors may help to build a broader vision of reproductive health and service delivery. Hence, this paper attempts to elaborate on relevant literature and it links them to the findings of these focus groups.

Methods

A formative qualitative study was designed and conducted for need assessment purpose by employing eight (8) Focus Group Discussions (FGDs) with men and women of reproductive age (15-49 years) who had at least one child. This study was conducted with the selected participants across the rural areas of the provinces of Punjab and Sindh. The areas of study included Farooqabad and Bagh (District Jhang) in Punjab and Bathoro (District Thatta) and Tando Bago (District Badin) in Sindh. Separate male and female FGDs were seen as the preferred protocol in order to discuss FP and reproductive health, which are considered private and highly sensitive topics. Two pilot focus groups were conducted; one in Sindh and one in Punjab, to test the focus group guide and to modify it as per the regional needs. However, no significant/major alterations were suggested after which the same guide was used for the rest of the focus groups. A purposive sampling approach was employed to recruit 80 participants of the target group (8-12 in each group) with an average size of 10

participants, both men and women had been identified and the participants were recruited through community contacts and a local non-government organization. Interviews were continued till the point of information saturation. The most commonly used form of nonprobabilistic sampling is purposive sampling and their size relies on the concept of "saturation", or the point at which no new information or themes are observed in the data or cutoff between adding emerging findings and not adding or when the researcher is no longer hearing or seeing new information. This number was considered an appropriate figure for this descriptive study and it was manageable within the resources and time constraints. The study participant criteria was married men and women, with ages between 18-48 years and having at least one child. The table 1 provides the information about the detailed sample size calculation in relation to the selected target areas.

Table 1. Detailed sample size calculation for selected target areas

Areas of Study	Men	Women	Total
Punjab			
Bagh (District Jhang)	09	11	20
Farooqabad (District Jhang)	11	09	20
Punjab Total	**20**	**20**	**40**
Sindh			
Bathoro (District Thatta)	10	10	20
Tando Bagh (District Badin)	11	09	20
Sindh Total	**20**	**20**	**40**
Total	**41**	**39**	**80**

FGD guides were used for eliciting information including the following topics such as social, demographic, knowledge, barriers and perceptions about reproductive health and FP, places and source of reproductive health and FP knowledge, practice of reproductive health and FP, type and kind of family planning services received, in-depth reasons for not practicing FP, perceived value of quality of services and free services and suggestions. The data collection/field work was done by local qualified data collection agency, sensitive to local cultural norms, under vigilant and close supervision of the Research and Metrics (R & M) team of the Marie Stopes Society in Pakistan, from September to October 2008. FGDs were conducted in Urdu and recorded after consent with strict confidentiality. The mean duration of each FGD was two (2) hours. It was then transcribed in English, verbatim and coded thematically using NVIVO software -- it is qualitative research software that helps people to manage, shape and make sense of unstructured information. It provides a sophisticated workspace that enables you to work through your information. With purpose built tools for classifying, sorting and arranging information, qualitative research software gives more time to analyze materials, identify themes, glean insight and develop meaningful conclusions. These codes were then refined, combined, and further categorized across transcripts to develop more general codes for further analysis by the R&M team. The participants (men and women) who responded to and completed the FGDs were 80. This represents a 100 percent response rate from the selected men and women who were eligible to participate in the study. This was a descriptive study and provided a thematic analysis of the relevant health issues by using an adapted constant comparison analysis process as described by Strauss and Corbin (5). This was done in accordance to the themes frequently and consistently emerging from the data. Considering the target population and nature of the objectives, and after formal approval from the R & M department at MSI London, United Kingdom; it was decided to use a qualitative research method for this study, i.e. the FGDs technique. Formal approval was sorted from R&M at MSI London. All study participants were asked to sign a consent form and confidentiality was maintained throughout the data collection, reporting and analysis. Study participants were told that they had the right to withdraw from completing FGDs at any stage. All the qualitative data was locked and kept for five years once analysis was completed. Tapes were destroyed once data was transcribed. No names were used in any reports or publications.

Results

A full description of the data analysis was given in the previous section. There were eight (8) key themes that were derived from the FGDs . They provided detailed insight into the contraceptive knowledge and use, barriers towards FP and service seeking behavior.

Attitude towards family planning

While women are more receptive to family planning, majority of men perceive it negatively. It is considered a taboo subject among them and something that does not concern them much. Interestingly, while in men's perspective FP is linked to the wellbeing of the child, it is not linked to the physical well being of women. *'My husband is very harsh to me and I had to keep my mouth shut always.*

But I did not want to have many children'. (Female, Bagh-07)

'We did not adopt it because we were told that it had adverse side effects'.

(Female, Bhatoro-03)

'Parents should look after the health of their children. Healthy children will perform better in all walks of life whether it is education or business. And this is only possible if the parents are able to provide them with education and good diet'. (Male, Farooqabad-14) Negative attitude of the provider, fear of side effects and misconception that the use of contraception reduces the ability of the women to conceive affect women's attitudes towards family planning and contraception.

'A woman complained that she went to see a lady doctor to seek medical help concerning birth spacing but was refused and was told that I was too weak for the procedure. She was told that you will have to face the side effects if you insisted to go through the process. Although, she said, her husband was very caring and was in favor of family planning'. (Female, Bhatoro-02)

We have practiced birth spacing and suffered the problem of not conceiving after a long time but we do not visit the doctors usually for that matter. Instead we go to the saints and their shrines to beg for their mercy and ask for their grace to deliver us the child'. (Female, Bagh-04) The women consider the role of mother in law highly influential in the family and the most crucial one influencing their decision to use contraception.

'My mother in-law doesn't like that we (me and my husband) should adopt some birth control method'. (Female, Bagh-11)

'My mother-in-law, who is my sardar (master/lord) and lives separately, says you should bear children because she herself had borne eight children'. (Females, Bathoro-12)

Knowledge of Contraception

Overall, both men and women display knowledge of various methods of contraception, although misconceptions still prevailed. The knowledge of traditional methods was higher than that of modern methods. This interest in FP suggests that those who were interviewed have an inclination to become users of modern FP, if provided with the information and access necessary to do so.

'One of the traditional ways of family planning is to avoid sex 10 days prior and after the menses'. (Female, Farooqabad-19)

'A woman does not conceive during the time her baby is on breast feed'. (Female, Bhatoro-22) "We would readily and happily adopt methods of family planning if we are provided the proper information." (Male, Bhatoro-21)

Sources of Information on FP

With the exception of television, information sources differed considerably between men and women. Women came into contact with lady health workers and lady doctors more often than men. Findings also reveal that men were relatively more exposed to multiple sources of information but that the knowledge was not shared with their wives. Similarly, the information women received from lady health workers was not shared with men. Within the couple, partners do not share information with each other openly.

'My husband brings condoms and we use this method. It is the men who know about these matters and perhaps discuss it with one another. The women are kept out of the loop'. (Female, Farooqabad-23)

'Lady Health worker talks to the females of the house only and mostly the wives do not discuss such matters with their husbands'. (Male, Bhatoro-26)

FP Decisions

In stark contrast to women, men preferred a larger family size and associated it with prosperity, while women preferred better standard of life and a healthy future for their child associated with a smaller family size and adoption of family planning. In addition, some male participants informed that the desire for son also led to larger family size.

'Most importantly, fewer kids lead to a happy life'. (Female, Bhutoro-30)

'Those who have five kids think that they should not have more due to inflation'. (Male, Bagh-28)

'Many people who have daughters want a son and this leads to an increase in their family size'.

(Male, Farooqabad-29)

Contraceptive use and Preferences

Of all the modern methods of FP, condoms received the most positive comments from amongst users and nonusers, irrespective of region and gender. The leastpreferred contraceptive method was injectables due to the side-effects associated with its use. The use of contraceptive pills was also not found to be very popular among the majority of female respondents. The most widely appreciated traditional method was 'breast feeding' since it had no side effects, and was seen as a healthy practice and beneficial for the child as well. Generally speaking, modern contraceptives are not very popular with the major barriers to their usage being low awareness, high cost and side effects.

'Condoms are the most convenient to use method, and above all it has no side effects'.

(Female, Bagh-33)
'Personally I think that usage of condoms is the mostconvenient method of all. We are using Saathi'. (Male, Farooqabad-34)

Majority of the men from Punjab district were not in favor of sterilization for being irreversible and this diminishes their chances of having more children in case of any unfortunate accident. In addition, men negatively perceived vasectomy and as against men' pride.

'In case of an accident where the child doesn't survive the husband and wife cannot bear more children in case they have already undergone a surgery. This would deprive them of having any more children'. (Male, Farooqabad-39)
'According to males this is something which is against their pride'. (Females, Farooqabab-40)

Barriers to FP

The following main barriers were noted:

1. Mothers-in-law and husbands (emerge as main social barrier affecting FP decision making).
2. Women bound by social pressure for fertility and fear of side effects
3. Financial costs for contraceptive services as focus group participants belonged to lower strand of the socioeconomic class (SEC).
4. Lack of availability and access to FP service providers
5. Religious interpretations

'My husband says that there is no need to worry about the expenses as I am the one earning and responsible for their (children's) bread and butter. Your job is just to give birth to my children'. (Female, Bhutoro-43)
'My husband as well as my mother in-law is against adopting any sort of family planning methods. I once told my mother in law that after my 5th baby I will get myself operated and will bear no more children. On this she said in a sarcastic note that she delivered and raised eight kids and I can't even manage 5?' (Female, Bhatoro-46)

Lack of health facilities providing FP services and information, restrictions on female mobility, money, and inlaws were identified as some of the main barriers to use FP services.

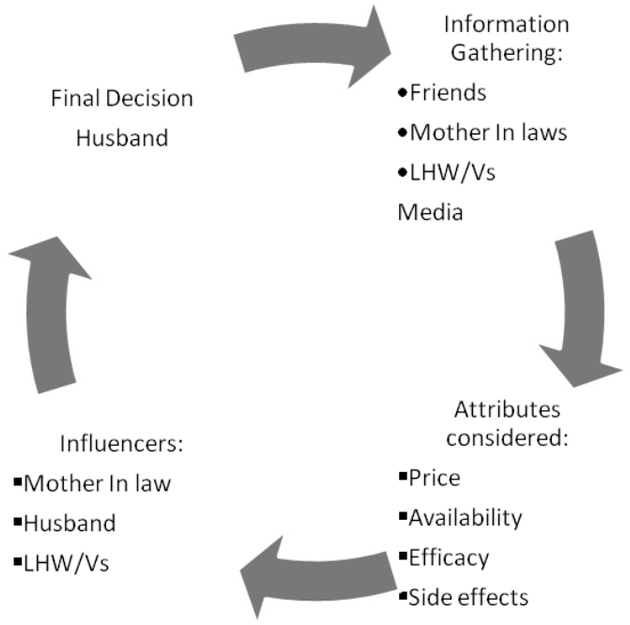
'We cannot afford it here because we are all very poor people.' (Males, Bhatoro-47)
'The reason for us not thinking about family planning methods is because no work has been done here in this regard. There is no one to guide us about it." (Male, Bhatoro-55)
'I never consulted any family planning service provider. We are not allowed to leave the house unaccompanied. Even if I would have wanted to go I would have taken my husband but he doesn't co-operate in this regard'. (Female, Farooqab-57)

Also, lack of antenatal care services was pointed out by the female participants in Sindh and delivering children at home with the assistance of Dai (TBA) was also considered economical by majority of respondents.

'Currently there is no institution in our locality where proper facilities are provided to a pregnant mother'. (Female, Bhatoro-54)
'Delivery through a Dai is economical. Our in-laws also consider it a better option as compared to hospitals'. (Female, Bhatoro-59) The table 2 shows the motivators and barriers associated with various traditional and modern methods.

Table 2. Motivators and Barriers Associated with different contraceptive methods

Modern Methods		
Type of method	**What is working?**	**What is not working?**
Condoms	• No side effects • Easy to use / Convenient	• Unreliable – danger of bursting • Costly • Reduces sexual pleasure
Tablets and capsules	• Inexpensive • Easily available from small stores also	• Have to be taken on daily basis • Heavy bleeding • Unreliable
Injections	• Prevention for 5 – 6 months	• Expensive • Heavy bleeding
Operation		• Expensive • Permanent method
Cooper – T / IUD		• Danger of dislodging from its place • Heavy bleeding
Traditional Methods		
Type of Method	**What is working?**	**What is not working?**
External Ejaculation	• No side effect • Free of cost	• Difficult to control
Breast Feeding	• Easy and has no side effects • Healthy method – Good for the child	
Safe days sex	• No side effect	• Difficult to keep the track of safe days



Decision Making Process

The decision making process across the participants was more or less similar. Figure 1 elucidates the decision making process identified by the participants.

Figure 1. Decision making process identified by the participants

Reasons for Seeking a Service Provider

Women do not routinely seek service provision except when seeking advice on method choice for FP. In addition, women mostly seek antenatal care services if the child is boy and deliver at home in case the child is a girl.

'Yes I took advice from the family planning center and followed the same; I got IUD inserted from there'. (Females, Farooqabad-60)

'When it is a boy we go to the hospital for delivery but in the case of a girl we deliver at home. We are told that it is easier to deliver the girl but extremely painful when it is a boy'. (Female, Bagh-61)

Perception towards Quality Health Care

Service provider preferences showed gender differences. Generally, the participants valued women and highly qualified providers with a cooperative and polite mannerism. Preferred health facility criterion included proximity and variety of services such as ultrasound machines, laboratories, and equipment/supplies for diagnosis of diseases and delivery services. Men emphasized on lower service charges. *'Low prices are the most important concern for everyone'. (Male, Farooqab-62)*

'I would prefer to have a satisfactory (effective) treatment and for this I am willing to pay the expenses'. (Female, Bagh-63)

Discussion and Conclusion

The results confirmed some trends previously revealed in some research studies (6) and surveys (2) as well as provided new insights into local perspectives regarding FP and reproductive health. The knowledge of contraceptive methods was low and misinformation was prevalent. Men thought of vasectomy as against men' pride and both males and females viewed removal of uterus as a permanent method. Method preferences were dependent on the side effect attached to the method for females whereas the men gave preferences to how economical it was. Despite theoretical understanding the benefits of FP, the actual method used was low corresponding with the findings of existing literature (7). Though importance of FP was recognized by the participants for the well being of the children and financial benefits of raising fewer children but the wellbeing of the woman was not considered a meaningful goal to pursue FP.

An underlying theme across most aspects of reproductive health was the lack of spousal communication and its negative impact on reproductive health behaviors. Within the couple, partners do not share information with each other openly and this finding also coincides with existing literature (8) and indicates that there is a greater need for spousal communication.

Along with the communication lag between husband and wife, husband and mother in law imposed their religious sensibilities and acted as social constraints. On the other hand, fear of side effects and health concerns also impeded use. Negative provider attitudes, misinformation on the part of providers and high service charges were also identified as barriers.

As the previous literature indicated (9), the problem of provider access was also highlighted as a major impediment as the participants either had to travel to other cities for services or go to untrained providers in their area. Besides access, barriers towards use included money, where frequency of use and choice of method was affected by financial limitation. A gendered perspective also prevailed with reference to provider seeking behavior. Women preferred going to private providers for delivery services in case the child is male and call a traditional service provider (Dai) and deliver at home in case the child is female and considered Dai as economical and reliable. Spousal communication is a topic mostly neglected by FP programs, yet many of the barriers are linked to it. There is a need to design health interventions that devise counseling techniques to improve spousal communication, debunk the myths and misinformation in the community,

and link the health of the child and mother with birth spacing and smaller family size (10). Developing interventions to improve the unfortunate situation of spouses who may want no more children but who have never broached the subject with each other has a huge challenge for development organizations, policy makers, as well as communications experts.

Limitations:

There are key limitations of this research that need to be taken into account when interpreting the findings. Specifically, this study was restricted by time and resources that were associated with the completion of the project. Also, this study was limited to a geographic area of Pakistan and so may not be overly generalisable. However it is felt that this study can be confidently generalized within a province in Pakistan. Applying these results to all of Pakistan or to Muslim communities generally should be done with caution. The experiences and therefore some of he perspectives might vary between people who work in predominantly urban areas. Due to the lack of research conducted with men and women especially about perceived value of quality of services and free services, it is difficult to estimate how generalisable the findings are to broader contexts.

References:

1. Singh S, Darroch JE, Ashford LS, Vlassoff M. Adding it up: The costs and benefits of investing in family planning and maternal and newborn health. New York: Guttmacher Institute and United Nations Population Fund; 2009.
2. National Institute of Population Studies and Macro International. Pakistan Demographic and Health Survey 2006-07: Islamabad; 2008.
3. Population Reference Bureau. World Population Data Sheet: USA; 2011.
4. Nishtar S. Choked Pipes. Karachi: Oxford University Press; 2010.
5. Strauss A, Corbin JM. Basics of qualitative research: Grounded theory procedures and techniques. California: Sage Publications Inc; 1990.
6. Casterline JB, Sathar ZA, Haque M. Obstacles to contraceptive use in Pakistan: A study in Punjab. Stud Fam Plann 2001;32:2.
7. Sultan M, Cleland JG, Ali MM. Assessment of a new approach to family planning services in rural Pakistan. Am J Public Health 2002;29:7.
8. Mahmood N, Ringheim K. Knowledge, approval and communication about family planning as correlates of desired fertility among spouses in Pakistan. Int Fam Plan Perspect 1997;23:3.
9. Hamid S, Stephenson R. provider and health facility influences on contraceptive adoption in urban Pakistan. Int Fam Plan Perspect 2006;32(2):71-8.
10. Shaikh BT. Unmet need for family planning in Pakistan-PDHS 2006-7: It's time to re-examine déjà vu. Open Access Journal of Contraception 2010;1:113-18.