

Assessing the Use of Contraceptive Methods for Family Planning among Married Women of Rawalpindi [urban]

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Abstract

Qualitative data from a survey of married women living in urban areas of Rawalpindi are presented here in an effort to better understand their views on contraceptive techniques and the factors that impact their use.

A purposeful selection strategy was used to choose participants, and only married women of childbearing age were eligible to participate. In total, 12 focus groups were held in the urban region of Rawalpindi. Some modern contraceptive methods were known to the majority, but overall use was extremely low. The prevalence of any form of contraception, including IUDs, was especially low. Modern contraception is not widely used because of concerns about side effects, religious apprehensions about harming the unborn child, a lack of information, or a lack of access to high-quality treatment according to the findings. The number of young women in the Pakistan who utilize contraception is influenced by social,

demographic, and economic factors. Young women's access to contraception may be restricted unless these findings are included into public health programs. Access to family planning information and services for young women is highly recommended.

Key words: Contraceptive Methods, Family planning, Urban areas, Rawalpindi

Introduction

Population growth, particularly in emerging countries, has raised a red flag around the globe. They have met their goal of restricting development in industrialized countries, and some have even seen negative growth. Due to the rapid expansion in developing countries, this effort is hampered. India is currently the second most populous country in the world, behind China, and is expected to overtake China by 2050 at its current development pace. In Pakistan, population increase is a major problem. The demographic needs of Pakistan are clearly out of balance right now [1]. With a population of over 184 million, Pakistan is the sixth most populous country in the world but has a big problem with poverty: 61% of its population lives below the poverty line [2]. In rural areas, where 65 percent of the country's population lives, about 45 percent of the population has limited access to public and private health care services [3]. Maternal and child health are two of the country's most critical development indicators [4]. In Pakistan, an estimated 28,000 women die each year from pregnancy-related problems that may have been prevented [3]. According to the World Health Organization in 2008, Pakistan was one of six nations responsible for more than half of all maternal fatalities worldwide [4].

A mother's and her baby's health are inextricably intertwined. As much as a third of newborns in Pakistan die as a result of maternal infections and other complications associated with pregnancy and delivery [5]. The health of Pakistani women is frighteningly low, which has a negative impact on the mortality and morbidity rates of both mothers and children. Pakistani women's lifetime risk of maternal death is estimated to be one in 93 based on current studies [6]. Half of all pregnancies in Pakistan occur with a competent health provider present, and women in rural areas or with lower levels of education are less likely to seek out skilled delivery care [3]. Both maternal mortality and the rural-urban disparity are significant in Pakistan, but the rural-urban disparity is even more pronounced. Pakistan's antenatal care coverage is far from optimal, with 27 percent of pregnant women receiving no care and 40 percent receiving no postnatal care after birth [3].

Newborn health and survival should also be a top target for improvement. Since the first PDHS was conducted in the mid-1980s, the newborn mortality rate in Pakistan has remained nearly stable. Regional differences were also brought to light in this manner [7]. If you take Punjab and Sindh, the 10-year NMR is substantially higher (58 per 1,000) than NWFP and Baluchistan (53 per 1,000). (41 and 30 per 1,000, resp.). 2.34% of all fatalities are due to pregnancy-related causes, according to a 2019 analysis from the Institute for Health Metrics and Evaluation. Not utilizing contraceptives for family planning is a major contributor [8].

At 17.4%, Pakistan's Contraceptive Prevalence Rate (CPR) is lower than the world average in urban regions, and it is significantly lower in rural and slum areas, contributing to both rapid population growth and poor health outcomes.

Youth in the study area are not using contraceptive methods because of myths and misconceptions, side effects, lack of proper knowledge about different contraceptives, unmet needs for contraceptives, socio-cultural and religious factors, and family planning service providers' own biases against or for use of contraceptive methods among the youth in the study area. However, it was believed that increased use of family planning techniques among the young people in the research area was linked to better education of youth and family planning service providers regarding counselling and contraceptive method use [9].

The purpose of the study was to assess the views of married women in urban areas of Rawalpindi on the usage of various contraceptive methods and to discover the factors that influence their use.

Theoretical framework

1. Methodological Orientation and Theory

The methodological orientation of this study is based on Grounded Theory.

Participant selection

2. Sampling

This study employed a purposive sample design by focussing on married women of reproductive age. FPC were selected at random from the neighbouring area. The eligible subjects were married women of reproductive age, residing in Rawalpindi.

3. Method of approach

Participants were selected non-randomly from women who visited the selected facilities for their own reasons and who requested if they can participate in an interview. A prior verbal consent was obtained from the participants before the interview. Interview questionnaires were signed afterwards for evidence and also as evidence of their consent. Efforts were maximally taken during recruiting and interviewing eligible participants in the study to avoid any potential selection or information bias.

A predesigned questionnaire was used by the investigator to interview the selected study participants. The questionnaire included sociodemographic information regarding age, education, family size, and family income, and questions covered awareness with regard to the concept and methods of family planning.

Data obtained was entered into Google forms, and analysed using qualitative analysis methods. Descriptive statistical measures such as percentages and proportions were used to express qualitative data during analysis. However, findings are narrated more in a qualitative manner.

4. Sample size

The team decided to conduct 16 interviews, 8 at most at each location. There were two different locations selected. However, 12 interviews were conducted with

married women participants in Rawalpindi area and the interviewers decided to stop the process as saturation point was reached.

5. Non-participation

The following exclusion criteria was used.

- All women who didn't wish to participate in the study were excluded.
- All unmarried women were excluded

Setting

6. Setting of data collection

The study was conducted in the urban area of Rawalpindi. Family Planning Centers (FPC) and Gynaecology Clinic at the Rawalpindi health facilities were the setting of this study.

7. Presence of non-participants

The interviews were conducted in isolation due to various questions of a sensitive nature. However, there were a few occasions, especially in the beginning, where the presence of a note taker as well a few technicians was required. However, in totality, this was a discussion between the interviewer and interviewee.

Data Collection

8. Interview guide

Interview guide was developed prior to administering the questionnaires. This helped the interviewers in asking relevant questions and keeping the interest of their respondents alive.

9. Audio/visual recording

Keeping in mind the sensitivity of the questions that were asked of respondents, the team decided not to go for audio visual recording. However, the utmost effort was employed in filling out the responses in a professional manner. All responses were discussed with the respondents after the interview for cross-verification.

10. Duration

Overall, 12 interviews were conducted with married women participants in Rawalpindi area on 10 January 2022. Each interview lasted for one hour approximately.

11. Data saturation

After 9 interviews the saturation point was quite evident, however the team decided to conduct 12 interviews.

12. Ethical Considerations

Health Services Academy, Islamabad Pakistan, gave the initiative its ethical clearance. To ensure the safety of the study participants, they were informed of the study's goal and the fact that they had the option of withdrawing from the interviews at any moment. When they were asked to answer a question, they were told that there was no "right" or "wrong" answer. This study's findings will not be reported

or published without their consent, and no identifying information about them will be made public. In addition, they were told that the audio recordings and hard copies of the transcripts would be stored securely and destroyed when no longer needed. Verbal and informed consent was also obtained from the study participants prior to the start of FGDs.

Data analysis

13. Derivation of themes

Overall, the questionnaire was divided into three themes, and the questions were asked accordingly. However, the themes were more thoroughly derived during the data synthesis and information recording.

14. Software

Google forms were used as the software to enter and manage data.

Reporting

A qualitative study was done to assess the views of married women in urban areas of Rawalpindi on the usage of various contraceptive methods and to discover the factors that influence their use.

Participants Demographic Information

All women were over 30 except one who was 23. 66.66% of women interviewed came from less than a 10 km radius. 25% of them came from less than a 1 km radius area whereas 8.34% of them came from less than 1/2 km radius area. 41.66% were house hold heads whereas 58.34% were illiterate. 58.33% were office workers and 41.67% were casual labourers. The maximum of individuals reported that contraceptives are used for family planning after giving birth to 4 children. The highest number of children is 6 and lowest is 2. (Table I).

Knowledge about Contraceptives – Uses and Access

50% of women reported to have knowledge of injections whereas 33.3% had knowledge of condoms and only 16.7% of women knew pills as methods of contraception. 33.3% of women learnt about the family planning methods from their friends and Radio And TV and health workers' advice were also a few sources narrated by the respondents making up 16.7% each. Word of mouth has more impact. 58.3% women preferred pharmacies to purchase contraceptive products. 16.7% women receive education through community health programs. Family planning clinics are also accessible but to only 25% of women. 66.7% women visit family planning clinics each month and 33.3% of them visit more than 3 times a month. 33.3% of women discuss family planning and use of contraceptives with their spouse/partner whereas 66.7% women and their spouse make a combined decision on family planning and use of contraceptives. (See Table II).

Table I: Demographics

Mean Age	33.25 Years
Locality	
10Km	8 (66.66%)
Less than 1 km	3 (25%)
Less than ½ km	1 (8.34%)
Literacy	
House Hold Heads	5 (41.66%)
Illiterate	7 (58.34%)
Employment	
Office workers	58.33%
Casual labourers	41.67%

Table II: Knowledge & side effects about Family Planning Methods

Knowledge of injections	6(50%)
Knowledge of condoms	4(33.3%)
Knowledge of pills	2(16.7%)
Learning about Family Planning Methods	
Friends	4(33.3%)
TV	2(16.7%)
Health Care workers	2(16.7%)
Radio	4 (33.3%)
Family Planning Services	
Pharmacies	7(58.3%)
Community Health Programs	3(25%)
Family planning Clinics	2(16.7%)
Visiting Family Planning Clinics	
Each Month	8(66.7%)
More than 3 times a month	4(33.3%)
Discussing Family Planning Services	
Spouse/partner	8(66.7%)
Combined decision	4(33.3%)
Side Effects	
Yes	10(83.3%)
No	2(16.7%)

Knowledge of Side Effects

80% of women have responded that they face side effects. Commonly reported are irritation, Hypersensitivity, leucorrhoea, burning, itching and vaginal discharge.

One of the women responded by saying that she feels swelling in her head and body pains. Otherwise there is no disease. It is also of interest to know that none of the respondents consulted health professionals for side effects. (See Table II).

Motivational Factors

83.3% women reported having knowledge of family planning whereas only 58.3% had used a method of family planning within the last 12 months. 33.3% women reported having cultural beliefs and 41.66% women having religious beliefs about modern family planning methods. Another motivational factor affecting their decision of family planning and number of children is their spouse as 33.3% of decisions are made by them whereas 66.7% of decisions are made by both of them. (See Table III).

Table III: Motivational Factors including Likes & Dislikes in Contraceptive Use

Heard of Family Planning	
Yes	10(83.3%)
NO	2(16.7%)
Usage of family Planning Methods	
Used within the last 12 months	7(58.3%)
Not Used within the last 12 months	5(41.7%)
Family Planning Methods Affected	
Cultural beliefs	4(33.3%)
Religious beliefs	5(41.66%)
Not affected by any belief	3(25.1%)
Decision of Family Planning	
Decisions are taken by spouse	4(33.3%)
Decisions are taken by both of them	8 (66.7%)
Dislikes using contraceptive method	
Spouse doesn't agree	5(41.7%)
They are not at risk	4(33.3%)
Culturally not acceptable	3(25%)
Desire for more children	3(25%)
Husband and in laws pressure.	9(75%)
Likes using contraceptive method	
Oral Contraceptives	5(41.7%)
Conventional Contraceptives	6(50%)
Injectable contraceptives	1(8.3%)

Some of the participants responses are given below:

- My daughter is still young. At the time of delivery, the doctor had explained to my mother that there was something to be avoided.
- My mother used to say that children should be reproduced with gaps. And there should only be two children, that's why I started using condoms.
- I had heard on TV that children should have 2 years of gap. After my daughter is born, I consulted with the LHW of the area and started the tablets.
- 4 children were born in my house then I thought that (should) stop now

Dislikes in Contraceptive Use

41.7% women report spouse doesn't agree using family planning method while 33.3% women think they are not at risk. 25% of women discontinued family planning method as they had a desire for more children whereas 75% had husband and in laws pressure. (See Table III).

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Mostly women couldn't narrate dislikes but after probing a few responded with side effects. Some of the participants responses were

- My daughter was 6 months old when I got an injection. I've been feeling breathing issues for the last 2 years now. I also get headache. I can't sleep at night. This has also impacted on my menstruation cycle.

- I have pain all over my body. My husband says it's all because of injections
- I have a stomach ache and feel like its burning.

Likes in Contraceptive Use

41.7% women preferred oral contraceptives whereas 50% women preferred conventional type and injectable contraceptives are preferred by 8.3% as it doesn't take much efforts and carefulness.

(See Table III).

The participants responses are given below:

- I wanted that I shouldn't have children in next two years. Since I am getting and consuming these things at home therefore it is convenient and better that I don't have to go somewhere else for family planning.
- Another woman prefers injection over tablets. She said that she used to take tablets but now she is comfortable using injection as it is convenient and doesn't require everyday use.
- I have a stomach ache and feel like its burning.
- This reassures me that the pregnancy is interrupted and that I do not have to do anything on my own and naturally there is a break.

Discussion

Women were more likely than men to get married at a younger age, which is in line with national statistics that show that on average, women get married at the age of 18. Men and women both agreed that having four children, two boys and two girls, is the ideal number for a family. However, boys received the majority of the votes. Males were shown to be more interested in having children than females, according to the 2012-13 PDHS [3]. Couples who want to reduce the number of children they have should enlist the help of their spouses (husbands) in the process of choosing on a family planning strategy [10]. Making decisions about the number of children to have and whether to adopt the FP technique together is rare.

Many of the participants had some knowledge of at least one modern contraceptive technique, including condoms, which is consistent with Pakistan DHS 2012-13 data [3]. Contrary to current national data, women believed that long-acting Intrauterine Devices (IUDs) were safer and had fewer negative effects than short-term techniques such as injectables and pills. IUDs were the most generally known procedure after condoms and female sterilization. As past studies have shown, men and women in these rural areas rely heavily on word-of-mouth to learn about local events and happenings [11].

According to a study in Vellore, Tamil Nadu, many women avoid taking contraception because they want children and are concerned about the possible ill effects. Modern contraceptive use was high in this study population, despite low levels of knowledge and moderate levels of positive attitude. Modern contraceptives were seen less successful by many women who preferred the more conventional techniques. The most common modern contraceptive method for women was sterilization [12].

Similar results were shown by a rural setup study conducted in 2015 Pakistan; the majority of the population was familiar with some modern contraceptive options, although they were rarely used. The prevalence of any form of contraception, including IUDs, was especially low. Modern contraception is not widely used because of concerns about side effects, religious apprehensions about harming the unborn child, a lack of information, or a lack of access to high-quality treatments. The vast majority of people preferred private health care facilities over government-run ones [13]. However, according to research conducted in Nepal, 81.3% of women in reproductive age were utilizing a modern method of contraception. According to educational attainment, 89.5% of women and 95.1% of husbands were literate, and 91.6 percent of women were found to be active in decision-making and to have effective inter-spousal communication, which is 93.3 percent [14].

According to research conducted in Sub-Saharan Africa in 2015-2016, 30.9% of women there utilized contraception. According to the data, young women in Malawi who are married, have children, are educated, have a job, and know the ovulatory cycle are more likely to take contraceptives.

Women who were 20–24 years old, married, aware of their ovulatory cycle, and with only an elementary education were more likely to use contraceptives than their counterparts were [15].

During the discussions, both positive and negative impressions about FP were documented. The good news is that women who took part in the study said that financial strain and increasing awareness were the two most important factors influencing couples to reduce their family sizes. Other factors that contributed to a lack of understanding and inhibited family planning uptake included societal influences (such as in-law and peer pressure on both genders), as well as shyness. Only a few men and women were honest about their use of contraception, whether it was recently or never. The most common reason given for not utilizing contraception was a desire to have more children

We must proceed with caution in light of the study's shortcomings, which stem primarily from its design. This is a qualitative study with a small sample size that may not accurately reflect the perspectives of the entire community it is intended to serve. It's also worth noting that this research included married couples from lower socioeconomic position who may have different perspectives than married couples from higher socioeconomic status.

Limitations:

Furthermore, the study's findings point to a lack of knowledge about various methods of family planning, a lack of health facilities offering high-quality family planning services, a lack of financial resources to access these services in rural areas, and social issues like peer pressure, mobility restrictions for women, and the disapproval of in-laws.

Long-acting and reversible contraceptives are needed in order to better understand local family planning practices, attitudes, and viewpoints. As attitudes regarding family planning and family size change, more women and couples will seek out family planning services. In order for women and couples to reach their reproductive and childbearing health goals, difficulties with access, pricing, and availability must be addressed. Both men and women expressed a desire for further children, and neither group felt the need to utilize contraception to any considerable extent.

Recommendations:

Female healthcare workers who are well-versed in long-term family planning methods like intrauterine devices (IUDs) and work in well-established institutions rather than pop-up clinics were also shown to be essential in the research. It also stressed the need of providing their communities with a man who is trained and knowledgeable about family planning and can educate other men about the advantages of family planning and birth spacing influencing decision-making at the household level.

It is possible to alter people's views on birth spacing techniques through well-targeted behaviour modification and communication efforts. Rather than allowing couples

to wait until they've reached their ideal family size before commencing contraception, these behaviour change efforts should encourage both men and women to begin using good birth spacing techniques as soon as they are married.

Efforts to promote collaborative decision-making between husband and wife about family planning and birth spacing should also include such efforts, so that spouses become responsible partners in family planning/birth spacing decisions and alleviate the burden of decision-making on women.

Through appropriate counselling and adequate information on method-related side-effects, we should be able to alleviate the anxiety of side effects. It's also possible to address social and religious concerns by incorporating community leaders, religious clergy, and health workers in awareness raising efforts.

Conclusion

Social, demographic, and economic factors influence the number of young women who use contraceptives in Pakistan. Unless these findings and their implications are incorporated in public health policies, young women's access to contraception may be restricted. It is strongly recommended that young women have improved access to family planning information and services in order to reduce the number of pregnancies among young women.

It sheds information on family planning practices, attitudes, and views in the local setting as well as the need for long-acting and reversible contraceptives. More women and couples will turn to family planning services as attitudes toward it and their intended family size shift. Access, price, and availability issues must be addressed if women and couples are to achieve their reproductive and childbearing health goals. The desire for additional children was stated virtually equally by men and women, and neither group felt the need to use contraception to any significant degree.

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