Abstract

Background: Efforts to expand access to reproductive healthcare in Pakistan dates as far back as the early 1950s. Despite such efforts, the fertility rate has declined at a slower pace compared to neighbouring countries.

Aims: The study aimed to explore the underlying reasons and challenges for long-time low contraceptive use among female clients and key service providers of community-based family planning (FP) programme of Pakistan.

Methods: A qualitative study was carried out with a total of ten focus group discussions and seven in-depth interviews with female clients and key service providers. The data were analyzed using qualitative content analysis.

Results: The intra-family dynamics, i.e. influence of husband and mother-in-law, are acknowledged as significant in shaping the decision-making and choice of FP methods. In addition, inadequate counseling skills, insufficient training for service providers, weak supportive supervision, interrupted supply of contraceptives, and delays in salary disbursement were among the key FP programme challenges.
Conclusion: Despite a well-designed community-based FP programme, providers’ counseling skills have to be enhanced. However, this has to be combined with sufficient training, supportive supervision and contraceptive supplies availability.

Keywords: Lady health worker programme, family planning, contraceptives, sexual health, reproductive health

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Introduction

On average, women in low- and middle-income countries have far more pregnancies than women in high-income countries, and therefore increasing their lifetime risk of death due to pregnancy-related complications (1). An estimated 303 000 women lost their lives during and following pregnancy and childbirth in 2015 and one third of these deaths were reported in South Asia (2). This statistic reflects disparities in access to reproductive healthcare (RH) – considered an essential human right – among low- and middle-income countries and possibly due to inadequate RH provision or under-utilization (3).

In order to reduce this rate of maternal death, the Safe Motherhood Initiative (a primary component of RH) has identified family planning (FP) as one of the four pillars of the initiative along with antenatal care, postnatal care, and safe delivery (4). Family planning is a substantive and effective primary prevention strategy for reducing maternal mortality by decreasing chances of unwanted pregnancies, lowering fertility (5–8) and lowering exposure to pregnancy-associated complications, thereby improving overall RH (4). As part of FP the use of
contraceptives is considered a cost-effective development intervention to accelerate progress across five Sustainable Development Goals (SDGs) (9). Despite an increasingly well-recognized and far-reaching impact of FP, the use of modern contraceptives remains low in many low- and middle-income countries, including Pakistan (10).

The current population of Pakistan is 184.5 million and has an annual growth rate of 2%; it is projected that by 2050, Pakistan will become fifth most populous country in the world (11). Despite six decades of government and private sector reproductive healthcare initiatives, Pakistan has one of the highest fertility rates and lowest contraceptive use rates among all of its neighbours (12). The average contraceptive prevalence rate (CPR) in South Asian countries is 53% (2013) while Pakistan has the lowest rate at 35% (13).

The provision of FP services and counseling to clients is a major task assigned to lady health workers (LHWs) of the National Program for Family Planning and Primary Health Care commonly known as the Lady Health Worker Program (LHWP), and is the largest community-based public sector RH initiative serving approximately 60–70% of women in remote and rural populations (14). The recent fourth external evaluation (Oxford Policy Management OPM 2009) of the programme has, however, identified only marginal improvement (33–34%) in CPR across the country, having increased only by 1% (15). Figures from the current Pakistan Demographic Health Survey 2012–2013 indicate that knowledge about FP among women of reproductive age remains universal, i.e. 99%, with a slight increase of CPR from 30–35%. The overall demand for FP is 70% with persistent unmet need. Although the Pakistan government remains the major provider of contraceptive methods, only 10% of users obtain their methods from LHWs (11).

The progress towards accomplishing Millennium Development Goals (MDGs) to increase CPR to 55% by 2015 remained unachievable for Pakistan. Given this context of modest increase in CPR and a high fertility rate in Pakistan, this article aims to explore reasons for low utilization of modern contraceptives among both end users and service providers (LHWs and lady health supervisors [LHSs]) of LHWP and suggest feasible strategies to overcome the issues identified.

**Methodology**

**Study design and setting**

The qualitative study was carried out from July to September 2013 in urban settings of Korangi district in Karachi. With approximately 20 million inhabitants, Karachi is the largest and most populous metropolitan city in Pakistan (16). The study participants were selected through purposive sampling from Korangi and Shah Faisal towns, which are covered by LHWP.
Study participants and data collection

The study participants were divided into two groups: 1) registered married women of reproductive age (15–45 years) residing in the study area for more than one year and seeking FP services from LHWP; and 2) LHSs and LHWs who have been working under LHWP for more than one year and providing FP services in the study area. The data were collected mainly through three Focus Group Discussions (FGDs) with registered females, seven FGDs with LHWs and seven in-depth interviews (IDIs) with LHSs. The interviews lasted for 45–60 minutes and each FGD comprised of 6–8 participants.

Data analysis

The discussions were audio recorded, then transcribed verbatim for qualitative content analysis. The codes were grouped into categories and similar categories were finally merged leading to main themes.

Ethical considerations

The ethical approval for the study was granted by the ethical review committee of the Aga Khan University, Karachi, and provincial and district programme implementation units of LHWP.

Results

The results of our qualitative study fall under two major themes.

Low uptake of modern contraceptives from the female perspective

Understanding reasons for low uptake of modern contraceptives from service providers lens

Low uptake of modern contraceptives from the female perspective

Most FP clients reported a positive impression about the use of temporary methods of contraception. They are more inclined towards use of condoms as the preferred choice, mainly because they describe them as being easy to use, readily available, has fewer side effects and satisfies their counterpart. The use of other temporary methods reported by the clients include; injections, pills and intrauterine contraceptive devices (IUCDs). Example of recorded statement is as follows:
“We use condoms. There are many benefits of it and no side effects. There is nothing bad. My health is good and my husband’s health is also good”

The Fear of side effects of contraceptives is reported as a challenge by female clients and may cause them to discontinue the use or switch to other methods with fewer side effects. The main side effects as mentioned by the clients include menstrual irregularities, palpitations, headaches, and weight gain. Example of recorded statement is as follows:

“Initially I was taking pills, and then I developed problems like palpitations, headache, nausea and stomach upset. I did not find pills comfortable to use and stopped therefore. Since then I am using condoms and I feel satisfied, and my husband is also happy”

Spousal approval is reported as significant in determining the use of contraceptives, as emphasized by female clients. It is mainly due to lack of approval or willingness of the husband that females face difficulty, despite their need. Beside spousal agreement and willingness the influence of mother-in-laws is described as another social barrier affecting the FP decision-making process. This influence was reported more in families where the husband is the only child and where there is birth of more female children. Examples of recorded statements are as follows:

“My sister-in-law is not using FP because her husband is not willing for its use. At present she has five children including one male child only. The husband has a desire for more sons. To fulfill his desire she already brought forth four daughters”

“I am a mother of six, every child born with a gap of 1.5 years. My husband is the only son and my mother-in-law forces me not to take any tablet or anything related to FP. She keeps a close watch”

Understanding reasons for low uptake of modern contraceptives through the perspective of service providers

**The community level**
Similar to the accounts of female clients, those of service providers (LHWs and LHSs) also revealed a high uptake of condom (despite high failure rates) followed by pills and injections. They described condoms as safe, easy to use and with added advantage of providing protection from sexually transmitted diseases. Also, at the household level, as explained by female clients, the influence of the husband and mother-in-law is considered significant in shaping FP decision-making by couples. In most instances it is the wife who is struggling hard for FP, while the husband seems less motivated. It is because of the lack of agreement and involvement of the husband that some of the females even use contraceptives without the knowledge of their husband and mother-in-law. Furthermore, in certain tribes the mother-in-law still believes in large families and wishes her son to follow in the same manner. Examples of recorded statements are as follows:

“The cooperation and willingness of husband is very important for successful practice of FP. The husband is very rigid and difficult to deal at times, and in that situation females face problems. If the husband is cooperative then it becomes easier for wives to practice FP”

“I visit two of my clients when the mother-in-laws are away from home. Because the mother-in-laws don’t want them [daughters in laws] to use contraception”

The service providers emphasized counseling to FP clients as a major task assigned to LHWs but in practice counseling is not provided to couples, but involves female clients only. In a society less open to talk about issues like FP, the service providers describe it difficult to provide counseling to males. However, they stressed upon effective engagement of men during counseling and decision-making because males require more awareness of their role for better uptake of contraceptives. The sehat (health) committee at village level includes male members and in addition to creating awareness on primary health issues, they could create awareness on issue like FP, especially for males. Example of recorded statement is as follows:

“Similarly male members of sehat committee should work with us. They may conduct continuous meeting with husbands or at least once a month to create awareness for FP. This will be very helping in counseling males as we mostly counsel females but not males”

**Reasons for low uptake of modern contraceptives at LHWP level**

Revisions in curriculum and refresher trainings
The participants mentioned that there are instances when the LHWs feel less capable to satisfy clients when they [clients] enquire more about FP than the information LHWs already share. To be more confident and able to satisfy clients, participants urged revisions to existing curriculum with inclusion of recent research and methods along with locally appropriate communication strategies to enhance knowledge and counseling skills of LHWs, particularly focusing on creating more awareness among males regarding uses and benefits of FP. They further expressed their dissatisfaction on frequency and quality of training sessions being held. Generally, LHSs conduct classroom sessions with the purpose of revision of certain topics. Since LHSs have limited information, qualification and skills, it is suggested to involve qualified trainers for conducting trainings for both LHWs and LHSs. Examples of recorded statements are as follows:

“I think in this changing context, current curriculum is not sufficient for us as we have confined our clients mostly to condom use only”

“Our curriculum needs revisions with updated information and new researches. The focus should be on providing adequate knowledge/information to men and women and motivating clients to use FP”

“I joined the programme in 1994 and received training from trainers who were experts in the field. They taught us everything in such a way that we became half doctors. If frequent and expert trainings are done, we can achieve 90–95% positive results”

**Inadequate supervision and oversight**

Generally, LHWs agreed that LHSs are supportive while few mentioned that LHWP should discourage induction of very young LHSs with relatively less field experience. For better performance of LHWs, the LHSs should also be evaluated on a regular basis for their supervisory and monitoring skills. Previously, the district and regional coordinators of the programme used to have field visits, but the current programme structure lacks a regular system for supportive supervision of LHSs. If included, this will encourage service providers to execute quality work, with increased sense of responsibility and accountability. Example of recorded statement is as follows:

“If LHSs have this thinking that they may have surprise visits from higher authorities, then they
LHS] will deliver the job with more sense of accountability and responsibility. In this way, they will be held answerable for performance of their LHWs"

Supply shortages and failures

Non-availability of medicines, FP supplies and stationary items is reported as a chronic issue for the past few years, because frequent medicine and supply failures have been reported by majority of the LHWs. The most commonly used contraceptives are condoms, but LHWs stressed that the quantity of condoms provided is insufficient to meet demand. This has resulted in increased pregnancies, for which the community blames LHWs. Example of recorded statement is as follows:

"The supplies are not sufficient for the whole community. For example, we get a very low supply of condoms. If we can just have a proper supply of condoms only, this will help us a lot"

Overall low motivation level of LHWs and LHSs

Frequent delays in salary disbursement and low job security are the main reasons reported for demotivation and eventually under-performance by LHWs and LHSs. It is difficult to meet household expenses with such low and frequently delayed incentives, especially for those who are sole bread winners (widows or divorced). Even after the decision by the authorities to make LHWs a permanent cadre, the service providers are still waiting for implementation of the orders. Example of recorded statement is as follows:

"It was in 2012 when the Court declared LHWs as a permanent cadre with increased salary, to be paid with arrears. But till date we do not have written proof of whether we are permanent or not? The Court’s orders should be carried out quickly as there is no implementation on ground"

Discussion

There is a great sense of encouragement demonstrated by female clients towards use of contraceptives. Regardless of fear of side effects and other barriers, they are still inclined to practice FP. On the other hand, despite having a country-wide FP programme, the intra-family dynamics (influence of husband and mother-in-law) are to date acknowledged as significant in shaping the decision-making and choice of FP methods. The opportunity of discussing the use of contraceptives with the husband not only empowers the wife but also impacts maternal and child health outcomes in the long run. Therefore, spousal concordance and communication are key for effective uptake of contraceptives – a finding supported by existing literature (17–21).
The influence of the mother-in-law is still voiced as a challenge at the household level. The underlying reason is considered to be rooted in different mind sets within the family dynamics such as 1) mother-in-laws who were less inclined to use FP themselves tend to influence their sons and daughter-in-laws to do likewise; 2) if the husband is the only son and 3) families where there is a desire for a son due to the birth of more daughters. Our study findings are consistent with findings from previous studies in Pakistan and neighbouring countries (22,23).

Counseling is one of the key components of the FP programme and affects the knowledge, use and spousal communication for use of contraceptives (24,25). Although counseling is reported to be the major task performed by LHWs, it is only to female clients without involvement of their husbands. Male engagement in counseling is an area not effectively addressed by the current programme structure. It can be assured through revitalization and involvement of male members of existing health committees, and by conducting awareness sessions for males regarding FP. This significant finding is supported by available evidence from other low- and middle-income countries (26,27) where male engagement in counseling increases uptake of contraceptives by creating awareness of methods, services (28,29) and improving spousal communication for method preference (30,31). In comparison to no counseling, couple counseling reported a 54% increase in uptake of contraceptives in a recent randomized control trial conducted in another Muslim country, Jordan (28).

Insufficient curriculum revisions and trainings to service providers, weak supportive supervision, interrupted flow of FP commodities and delayed salary disbursements are other key programmatic areas not sufficiently addressed by LHWP. These findings are supported by a recent external evaluation of LHWP, which has highlighted key programmatic impediments to be seriously addressed (32). Despite current low strength of LHWs, there is a significant community acceptance of LHWs since they have demonstrated potential to deliver services.

Therefore, appropriate curriculum revision, shifting from more theory to practical approach and addition of effective interpersonal communication skills can better equip service providers for counseling clients. The in-service training and professional development is an important contributor towards maintenance of competencies for delivery of quality services by community workers, especially in low- and middle-income countries (33). This can be achieved with appropriate modifications to delivery and design of in-service training with revisions to curriculum, and overall assessment of performance (14,33). Simultaneously, effective supervision by LHSs through improved skills assessment, feedback and reinforced regular supervisory visits, along with good district management practices for timely availability of supplies and salaries, are important for improving overall productivity of service providers and hence uptake of modern contraceptives. When supply of essential commodities is disrupted, not
only will the productivity of LHWs decrease, but there may be other consequences such as losing respect from the community, without which the desired tasks cannot be executed.

**Trustworthiness**

The criteria of Lincoln and Guba were followed in order to achieve trustworthiness of the study (34). Credibility was obtained by selection of appropriate participants, the context, appropriate interview guides for FGDs and IDIs, and by choosing representative quotations from the transcriptions. Dependability was assured by conducting the FGDs and IDIs over a period of one month, so that phenomena under study will not change in the communities. All the FGDs and IDIs were conducted in the local language and moderated by researchers well versed with language and context. Conformability was achieved by separate coding of teams followed by discussion on similarities and dissimilarities.

**Conclusion**

Our analysis suggests a comprehensive and integrated approach involving individual, community and management level stakeholders in order to address the challenges indentified by the study participants, for enhanced uptake of modern contraceptives in the LHWP.

**Individual level**

The LHWs play a pivotal role in the healthcare system of Pakistan. There is strong potential to enhance counseling and interpersonal communication skills of LHWs and LHSs – a major contributing factor for acceptance and practice of FP. It is the basic right of couples to decide freely the number and birth spacing of their children. Thus, effective counseling and communication is the way to provide adequate information, education and the means to do so.

**Community level**

Since FP/birth spacing choices rest more on a couple's decision than on women's alone, revitalization of the health committees at community level is strongly needed to promote effective male engagement in RH initiatives designed to improve women and child health and particularly FP services. Integrated and well targeted behaviour change communication (BBC) activities and community mobilization/awareness campaigns can help address socio-cultural issues and misconceptions about contraceptive use, and so imparting a considerable positive impact on awareness and acceptability of FP among community members as part of demand creation efforts. Moreover, the involvement of relevant stakeholders, such as community leaders, religious clerics and health activists in the health committees and various BBC
modalities, will lead to substantial community ownership.

**Management Level**

The above has to be combined with strategies to strengthen the existing programme structure, such as adequate and periodic needs-based assessment of LHWs and LHSs, sufficient training, and effective supportive supervision (both technical and supervisory) of LHSs. Furthermore, giving greater financial control to district health departments with oversight by provincial level stakeholders can potentially improve availability of funds for salaries, supplies and stationary. Lastly, a significant period of time has elapsed since the last evaluation (OPM 2009), therefore re-evaluation of the LHWP may be carried out in order to track the progress and shortcomings.

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**References**


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