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Original Research Article

Beneficiaries perceptions on motivation to family planning intervention in a community of Karachi Pakistan

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ABSTRACT

Background: Pakistan is facing a great challenge in planning, implementing, and sustaining family planning and birth control policies. Considering this, one of the community health programs in the outskirts of a community health worked led family planning counselling. The purpose of this research study is to highlight perceptions of the beneficiaries regarding the benefits of the same.
Methods: A qualitative descriptive study was undertaken for this investigation using a non-random sampling technique. The sample was chosen from the community population who were part of this intervention, with an inclusion criterion. The data was collected using in-depth interviews from 13 participants in total.
Results: The key themes emerged across the interviews: Unfolding myths: Participants' recognized that using family planning mediums does not mean that there is a medical deficiency outcome to it but a way to prevent large families, societal pressure: Participants shared the issues and cultural taboos attached to the family planning and how it is conceived in their societies, program support: participants shared that having a female lady health worker coming to the home brings in more access to the family planning and benefits: they found that effective and structured family planning is contributing to their enhanced personal life relations, economic gains and social comfort.
Conclusions: A community health program model can be one of the outlets the government can collaborate to offer door to door provision, service quality and access to family planning to such communities in need.

Keywords: Community mobilization, Family planning, Perceptions of couples

INTRODUCTION

Family planning refers to information, means and methods to control family size. It is an imperative component of reproductive health and well-being, which is a critical for achieving sustainable development goals (SDGs) good health, quality education, gender equality, decent work opportunities and climate risk mitigation.[1,2] The benefits of family planning, both immediate and long term, are well established in literature. It can reduce maternal and child mortality, abortion rates, improve delivery outcomes and impact women's autonomy a financial stability.[3,4] Additionally, contraceptive costs are significantly lower than pregnancy related expenses. This can not only alleviate the financial burden on individuals and country's healthcare system, while also boosting the country's economy by allowing women to be active participants of the workforce.[5] Despite increasing rates of family planning

globally over the last few years, the UN population. Division's report in 2020 showed that approximately 257 million women in developing countries had an unmet need of family planning.[6,7]

The consequential increase in healthcare related costs will only impact the economy of the developing countries adversely. This is why with the current economic crisis; adequate family planning is of utmost importance to Pakistan. Access and provision in uptake of family planning remains a major gap in the country, particularly in underserved, marginalized and resource constraint areas. A quarter of married women who want to space out their pregnancies were found to not be using any method of contraception at all.[8] Therefore, there is an imminent need to scale up family planning interventions. Pakistan has faced innumerous challenges in promoting family planning, specifically in rural areas. Pakistan demographic health survey reported low rates of family planning among women with a socioeconomic background of poverty and illiteracy.[9] From access of preventive good, to low education and awareness to cultural and social taboos, the barriers to family planning are a plenty. Many studies conducted in Pakistan talk about traditional beliefs and gender norms along with societal pressure as barriers to family planning, especially in rural communities.[10] In Karachi, fisherman community is one such community living in under resourced and impoverished conditions. Other than challenges of access, low education, and cultural and societal barriers, they lack access to healthcare facilities and family planning education, due to high rates of illiteracy, lack infrastructure and skilled healthcare workers, are additional important challenges they face.[11,12]

In heed of these issues, Pakistan has launched several programs on providing education for family planning, particularly for disadvantaged communities.[13] Under the auspices of governmental interventions, the lady health worker programs initiated by the Ministry of Health in the early 1990s, along with non-governmental organizations have had encouraging effects.[14] Another intervention found that apart from the integration of community health workers in the community, subsidizing family planning products and services through vouchers also increased the use of contraceptives.[15] One such intervention conducted was by a non-governmental organization that participated providing family planning intervention in a community of Karachi, Pakistan. The intervention included door to door visits to provide family planning education. This study aimed at exploring the impact of this intervention and the perceptions of community beneficiaries regarding the motivation to family planning. Exploring this community in particular was deemed necessary due to a lack of existing literature regarding their lifestyles and concerns, and a consequent lack of relevant interventions. Secondly, they are an important part of Sindh's population, with unique motivations and challenges that need to be explored for targeted promotion of family planning education and provision.

METHODS

Design

Qualitative descriptive study design was chosen to collect the experiences of the people who were part of the intervention. Taking qualitative study designs allows investigators to explore ideas, experiences, perceptions and stories around the topic.[16] In Pakistan, it is hard for the communities with low or no education to fill forms hence qualitative study allowed the investigators to do one to one interviews with the couples to understand their perspective regarding the phenomenon.

Research setting

The intervention site of the district was Karachi peri urban. The district is located at the end of Karachi's coastal areas. It's a big district of Karachi with nine union councils under it.[17] Communities there have resource constraints, some living below poverty line with public health issues leading to morbidity, mortality, and low literacy.[17] An intervention to educate the vulnerable communities of Karachi on family planning was conducted. These communities suffer from lack of access to quality housing, healthcare, and education, and have limited means of earning, resulting in malnourishment. With an average household size of 6-8 people, the area has a total population of 100,000, including 16,000 married women of reproductive age. The community was chosen because of their low health and wellbeing indicators and high population rates.

Sampling

The intervention was implemented in the entire community. All houses were chosen to provide counseling. From the ones that agree to opt for the family planning interventions, a non-random purposive sampling was administered. Inclusion criteria included choosing the female and male who were part of the intervention and have actively availed any family planning services from the healthcare center. Whereas the ones only opted for counseling sessions and no services were excluded. From the filtered population, a set of 12 females and 6 males were approached. From which only 7 female and 6 males agreed to participate and the final sample size was 13 overall. From the sample there were 61.5 participants who were in the age category between and 38.5% were between 35-45. As for the qualifications, only 1 had passed their matriculation whereas 6 were illiterate.

Data collection

We used semi-structured interview guides with probes. The questions regarding the experience of the intervention by the community, what pressure have the couples faced regarding opting for family planning, what myths were unfolded, the type of support they received from the health workers, and what benefits that availed through the intervention. Verbal consent was obtained, and

participants were invited to a local community center. The interviews, conducted one-by-one in a private room, were in local language and audio-recorded; recordings shared only with research team and labeled with unique de-identifying code, stored in password protected drive. Females interviewed one day, males the next, to ensure comfort regarding the sensitive matter. The study was conducted in the months of October 2018 to November 2018.

Data analysis

Data was transcribed, forward and backward translated in Urdu and English, open coded, and patterns were identified. Later, based on the codes, themes were generated. For every theme, there were verbatims chosen and analyzed. All the qualitative data was analyzed manually. Informed consent was taken from all participants, and anonymity was assured, with the right to withdraw. The study was approved by an intervention institute's health education committee consisting of one health care expert, one legal officer, and one subject expert, due to the absence of an ethical review board.

RESULTS

In this investigation, we asked several questions regarding perception of family planning, provision available to access family planning, self-experienced impact, and barriers to family planning. Most the data that was stipulated was around the general perceptions.

Table 1: Distribution as per demographic details.

Category	Description	N	%	Mean
Gender	Female	7	53.8	1.46
	Male	6	46.2	
Age range (years)	25-35	8	61.5	1.38
	35-45	5	38.5	
Qualification	Illiterate	6	46.2	2
	Primary	2	15.4	
	Secondary	4	30.8	
	Matriculation	1	7.7	

The emerged theme intertwined in participants' narratives and we merged them as: family planning and its perceived benefits and unfolding myths and societal pressure. Most participants had understanding of family planning after the intervention of the program. They were able to define it in general terms that this is the way of giving birth space between children and planning family in a way that is manageable. We found that families were also hesitant in sharing the information regarding family planning or using this word. One of the participants mentioned: “I did not know about family planning before, in our culture, it is not accepted that we talk about it or discuss it with someone. I have 7 children, one after the other, never before anyone told me that there is any such concept like family planning”.

Another participant shed light on how this topic is never discussed in the healthcare facilities they go to, they mentioned that there is no lady doctor available to teach them. One of the male participants also shared this concern and mentioned, “There is only one doctor who comes once a week and there is a long que. My wife stands for 6 hours in que to get to the lady doctor. We are not allowed in the room, so I stand outside. There is no other doctor to explain us what can we do ensure a good health for myself and my family”. Participants shared that they now feel facilitated as there is an institution that sends lady health workers at their house door to provide counseling and education regarding family planning and if their husbands are around, they also sit and listen to their advice. They also provide nutritional counseling, counseling to manage health issues and tips to manage health of our children. “A very good impact on our life. There were daily disputes between husband and wife. I was unable to give time to my mother-in-law. She always taunted me. My house was totally mismanaged. Everyone remained in depression. Since I started family planning all the problems were solved dramatically. Now my mother-in-law, my husband and my children are all happy. I can give quality time to them. I put oil and give massage to my mother-in-law. She is also very happy now and prays for us”.

They mentioned past issues with personal relationships, finances, parenting, and that family planning resulted in lifestyle improvements. “Yes, if there are lots of children then it becomes very difficult to manage. I am unable to give time to my husband, so he gets angry with me. I can’t obey my mother-in-law then she taunts me daily. So, what shall I do? Sarafeen sister came to me and advised me to keep this capsule saying your health will also remain good and will be able to please your husband. You will also be able to give time to your mother-in-law and children. It was very good advice and I will remain very much grateful to her”. Participants found the model of door-to-door family planning to be beneficial and suited to their needs. All participants had an understanding of family planning after the intervention program, though they previously considered it a sin, with many societal taboos and myths attached. They episodically refused gaining awareness due to preconceived notions, and the belief that the number of children affects a family's social standing being common in their community. “People in neighborhood used to warn us because they associate so many problems with it like your menses will be stopped etc. I haven’t paid attention to any of that”. Participants before this intervention viewed family planning methods against their ideology and thought it was a way through which their reproductive status will be tempered. “First, my mother-in-law and my husband both did not allow me to use. Then I explained its benefits to my husband. Eventually, he understood, so now I am using it. I have also encouraged my friends and relatives to use it”. Participants shared that with the proper counseling over a course of time has changed their perception towards it. They are now more inclined towards family planning and being critical of their needs and means towards family progression. As one of the participants

shared the burden of no family planning: “I had four children consecutively. I could not understand how to manage. Then someone told me to take advice from organization lady workers. So, they advised me to take Chabi tablets or injection or keep the capsule. Anything which suits you, but you must give a pause. Your children would be fine, and you would also remain healthy. Then I decided to keep the capsule ring (IUD)”. Participants shared that advocating for family planning is not common communication, and they restrict discussion with others. To this, one of the participants shared: "Yes, we refer those who are very much close to us. We can’t tell everyone about it; but those who are close friends, we tell them often about this thing." From participants' viewpoint, societies and communities need ample support, counseling and access to family planning. Despite many people accessing it, there remains a knowledge, attitude and practices gap with those who don't.

DISCUSSION

The first question focused on exploring the perceptions regarding family planning and its benefits. From the results, it can be seen that participants initially did not have understanding of the family planning. This can be found common in areas with low education rates and the areas that living in the poverty level. Several studies talk about how socio-economic factors can impact the knowledge of family planning.[18] In lower middle-income countries this phenomenon of no knowledge regarding family planning can be seen common for several reasons starting from education to cultural taboos and one major being lack of counseling pertinent to family planning.[19] Other findings focused on benefit of door-to-door counseling model that participants shared that this lady health worker visiting to provide family planning education was effective for them to implement family planning. Research studies shares the potential benefits of lady health care worker engagement in providing family planning counseling. This can be seen in various studies.[20]

The major theme emerged from the participants' data during in-depth interviews with 13 participants (7 females and 6 males). Focused on the myths and societal pressure around family planning, which included many misconceptions about adverse effects on reproductive health, childbearing and marital relationships, likely due to low awareness in low-resource countries. Low-income areas especially face limited access to healthcare, with inadequate information and quality services, consequently decreasing the quality of life. Women in countries such as India, Pakistan, Zambia, Kenya, and Guatemala have a great unmet need for family planning and contraception leading to inability to prevent pregnancies and plan intervals between pregnancies.[21]

Research shows many women in low-income countries wish to space out pregnancies, but lack of knowledge, attitude and access to contraceptives prevents them.[22] The results of our investigation indicated that, despite knowledge, lack of access and cultural taboos, attitudes and misconceptions were major obstacles to women's family planning. Culturally-appropriate counseling and government initiatives promoting wider contraceptive distribution could significantly increase family planning prevalence in Pakistan and similar countries. Another similar theme emerged was that women face many challenges in making family planning decisions due to family pressure, lack of understanding of community. Other studies also corroborate that this is a common phenomenon in low-middle income countries.[23,24] Addressing it through counselling and distribution of contraceptives by CHWs are an effective intervention. Detailed interviews showed significant trust in lady health workers, accepting their teaching, and being grateful for the change counseling brought.[25] Research has proven that CHWs and professional healthcare providers can leverage good relationships to inspire families to seek family planning, thus increasing contraceptive use and providing knowledge and support for state-led health programs and interventions, even in areas with low facility coverage. The another identified theme was the perceived benefits on participants’ families. Many participants shared the positive impact and benefits of family planning, with some mentioning its effect on overall family wellbeing. Lack of planning can cause economic and other family dynamics issues. This finding is in line with existing literature. Family planning is an important preventive health service for women, empowering them to space pregnancies, enjoy good health and quality time with family, and lead a productive life.[26,27]

The participants believed that continuation of structured family planning decisions by a family can not only empower them economically but will also impact the health and education indicators of the generations to come. Several studies share the impact of family planning on a country goes beyond population control. Awareness and availability of good family planning is key to achieving the Sustainable Development Goals (SDGs), promoting gender equality, health and poverty alleviation.[26,27] Abundant research exists on family planning benefits; WHO & UNICEF advocate quality planning and health services to prevent unwanted pregnancies, reduce mother and infant morbidity/mortality, empower families, enhance education and productivity, prevent communicable diseases & slow population growth.[28] This will in turn, benefit not only the healthcare of a country, but also the socio-economic climate. The participants focused on the provision of continuous support from the health care workers. To this most of the participants mentioned that the support from the healthcare workers provided them with the routine guidance and they were also providing resources for family planning. However, discontinuation of such intervention can have negative impact on the communities and their decision for family planning as affordability and access of family planning resources are a major challenge.[29,30] Since, the program intervention has closed out the communities feel a gap in healthcare service provision. This is well noted in various

studies conducted in Pakistan. Pakistan has a patriarchal society, with frequent gender-based inequities in health, education, career prospects, income, personal security, and asset control.[30] On the list of 151 countries, Pakistan is third from the bottom, according to the World Economic Forum's Global Gender Gap Report Women have various, well-documented obstacles to healthcare, including restricted decision-making abilities.[20,31,32]

CONCLUSION

Family planning could reduce poverty, support health, education, and gender equality, as well as lessen burden on Earth's natural resources. This could also lead to peace, equality, social justice, and economic growth. Government should strategize an integrated intervention model with support of journalists, civil society, and local groups to achieve the Pakistan 2020 family planning target soon. In Pakistan, discussion regarding family planning remains difficult due to taboos and stigmas. There are a few studies that talk about barriers and enablers but areas which are socially resource constrained have lesser opportunities for evidence representation. From the findings of the research can be stipulated that there is a need to explore barriers and societal challenges regarding family planning, government and civil society organizations must continue free and accessible provision of family planning services and counselling door to door where required. Policy level changes are also required for a structure family planning program and their transgenerational health impact.

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