

Perceived individual and community barriers in the provision of family planning services by lady health workers in Tehsil Gujar Khan

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Abstract

Objectives: To identify contextual barriers (social, cultural, geographic and economic), faced by Lady Health Workers (LHWs) and to assess their strategies at different levels (individual, community and system) in the provision of family planning services to their clients in Tehsil Gujar Khan.

Methods: The mixed model cross-sectional study was conducted from April 1 to July 10, 2010, in Tehsil Gujar Khan, Punjab, Pakistan. It was carried out in two phases: in the first phase 10 in-depth interviews were conducted with the workers, followed by two focus group discussions. On the basis of findings, a structured questionnaire was developed and administered to 111 workers in the second phase. Of the total, 97 responses were used for analysis. Data analysis was done by SPSS-16.

Results: Majority of the respondents reported barriers at the community level: religious barriers 69% (n=67), socio-cultural barriers 58% (n=56), transport 54% (n=52), communication and economic reasons 25% (n=24). Individual level barriers were female gender, experience and low education. System-level barriers were increased workload, National immunization days/sub-national immunization days, late supply, stock shortage (especially injectables), problems for referred clients and lack of proper incentives.

Conclusion: Lady health workers still face barriers at individual, family, community and system level in the delivery of Family Planning services.

Keywords: Lady health workers, Family planning, Barriers. (JPMA 62: 1318; 2012)

Introduction

Pakistan is the sixth most populous country in the world, with population growth and unmet needs (25%) and with total fertility rate (TFR) (4.1) highest in the region and contraceptive prevalence rate (CPR) being only 22%.¹ This unmet need is the product of both lack of adequate services and a social milieu that is generally unfavourable to the adoption of contraception.² Pakistan is having successful large-scale community programme of 100,000 Lady Health Workers (LHWs).³ LHWs are providing all essential health services to the community at the doorsteps, including access to Family Planning (FP) services.⁴ LHWs provide primary healthcare in different parts of the country and the provision of FP services is one of their main components.⁴ LHWs have a positive impact on the health of mother and children and directly contribute to the use of modern contraceptives.⁵ There was substantial increase in the use of contraceptions in Pakistan after the 1980s, but later on there was a plateau and the reason was the lack of ownership of FP services by LHWs at the community level by the provincial and district health departments.¹ There is also a gap between contraceptive knowledge and use and only 41% women of child-bearing ages (CBAs) are using modern FP methods,

which are being counselled by LHWs.¹

More than half of the LHWs face barriers for FP services and in Punjab 42% of the LHWs encounter barriers in the delivery of modern contraceptives to women of child-bearing age.⁶ Barriers exist for FP services at different levels and studies have demonstrated the various barriers at different levels e.g. economic, cultural, cognitive and administrative barriers (weak management, low coverage and poor quality) to the FP uses both for healthcare providers and users.⁷⁻⁹ Nevertheless, little literature is available identifying social, cultural and organisational barriers for LHWs at the community level.¹⁰ A range of factors affect the use of modern contraceptives by women and these include lack of knowledge, obstacles to access, lack of control, side effects, cultural beliefs and norms at the community level, especially about the use of condoms (easily available) especially the thinking of condoms' association with disease and promiscuity due to greater male control.¹¹ A number of studies and surveys point towards a high knowledge and low use of modern contraceptive in Pakistan. Rural population in Pakistan has the lowest use of modern contraceptives, because these areas are difficult to be accessed by LHWs.¹⁰ There are also

restrictions on women mobility and other social barriers (access of un-married girls to healthcare). Here women's access to FP is restricted despite the growing contraceptive rate.¹² The barriers to the low use of contraceptives and related health system issues have been looked into by various studies and evaluations. However, the problem at Community Health Workers (CHWs) and client interface remains largely unexplored. Following the evaluation of LHW Programme in 2001, the need for a qualitative study to identify the various factors that could impinge upon FP was recommended as part of "further qualitative research on the dynamics between LHWs and their female clients to better understand the processes that lead to uptake of modern contraceptive methods."¹³

It has been emphasised that efforts aimed at promoting modern contraceptives use in Pakistan must consider the issues of affordability, accessibility, quality of care and ease of use of various modern FP methods. Socio-cultural beliefs and perception of the community about various methods must be explicitly addressed for any intervention to achieve high uptake of modern contraceptives at community level.¹⁴

This study was planned to explore barriers faced by the LHWs on the supply side, i.e. provision of the FP services in their communities. The study attempted to gain a better insight about the different barriers to FP at the LHWs and client interface in the community. The various dynamics associated with women's initiation and continuity of contraception is an unexplored area. The evidence can help in increasing the use of modern methods of contraception through community-based strategies, and further enhance the role of LHWs in the provision of the FP services in their respective areas.

Subjects and Methods

The mixed model cross-sectional study qualitative and quantitative was based on the Reproductive Health Conceptual Model for Developing Countries.¹⁵ The study was carried out from April 1 to July 10, 2010, in Tehsil Gujar Khan, Rawalpindi, on LHWs. In the formative phase the respondents were purposively selected for 10 in-depth interviews and two focus group discussions (FGDs). In the second phase, a structured questionnaire was administered to randomly selected 97 LHWs. For structured questionnaire in sample size estimation, the WHO sample size calculator was used, in which the following formula was used at 95% confidence interval:¹⁶

$$n = z^2 p(1-p) / d^2$$

In the equation, z is confidence interval (value 1.96), p is the anticipated population proportion (the number of LHWs who face barriers in the delivery of modern Family

Planning methods taken as .50 or 50% according to Pakistan Demographic and Health Survey (PDHS) 2006-07) and absolute precision required is 10%, in which the sample size 'n' was calculated as 97 respondents.

Pre-testing was done both for field guide and structured questionnaire. Ethical considerations were reviewed by the Ethical Review Committee/Board, Executive District Officer (EDO) Health Rawalpindi, and written consent was obtained from the respondents.

In the first phase, data was collected via 10 in-depth interviews and two FGDs over a period of two weeks. Then a structured questionnaire was prepared based on in-depth interviews, FGDs and literature review, which was administered to 111 LHWs. For statistical analysis only 97 responses were used to match the sample size calculation. In-depth interviews and FGDs were transcribed via expanded notes. Framework analysis was used. Structured questionnaire data was entered in SPSS version 16. Data was analysed with the addition of some new variables. Descriptive analysis (univariate analysis) included frequencies of all categorical variables and mean of continuous variables.

Results

The mean age of the LHWs was 36±7.72 years (range: 19 to 57 years). Of the total, 90% (n=87) were attached to Basic Health Units (BHUs), while 10% (n=10) were attached to Rural Health Centres (RHCs). Two-thirds were married, had good knowledge of FP and were considering all the important factors like the number of children, maternal age before start of FP methods. They were counselling for FP during daily visits to the clients' homes (daily 5 to 7 household visits). Clients also visited the house of LHWs for counselling for FP, follow-up or for taking contraceptives. Main reasons for not visiting the field were meeting at the health facility 86 (89%), NIDs/SNIDs 75 (77%), problems in LHWs' home 74 (76%) and problems in client's home 68 (70%).

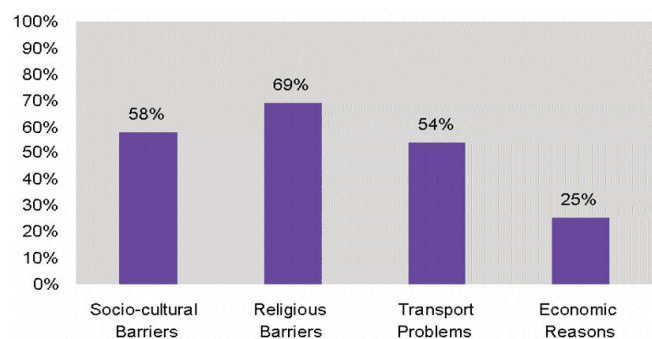


Figure-1: Major barriers in the provision of modern family planning methods.

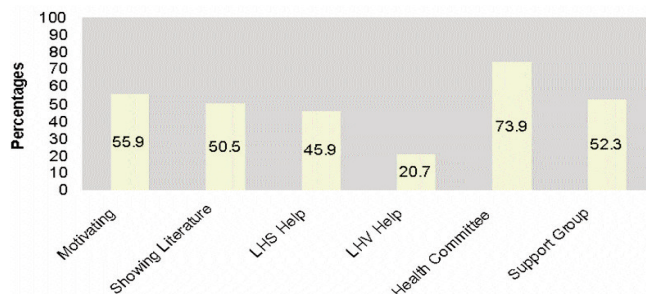


Figure-2: Different strategies of lady health workers to overcome family planning resistance.

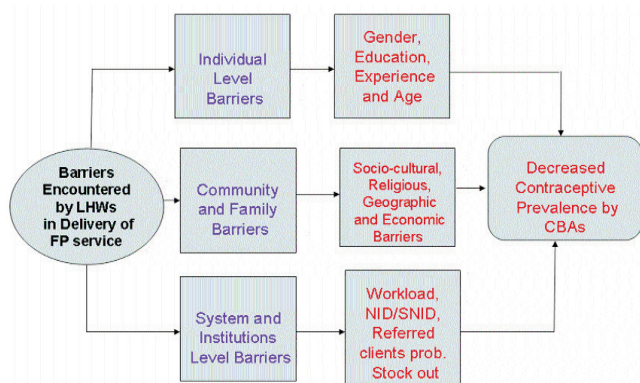


Figure-3: Perceived individual and community barriers in the provision of family planning services.

The LHWs reported barriers at three levels: individual, community and system levels. These barriers were more at the community level (Figure-1). Major socio-cultural barriers were lack of education (n=63; 64%); excessive domestic work (n=58; 60%); family pressure (n=51; 53%), and limited mobility (n=13; 13%). Of the respondents, 76 (78%) reported that the presence of mothers-in-law inside clients' house was a barrier. Husband resistance was reported by almost half of the respondents followed by sisters-in-law and elders (n=16; 17% each). Religious barriers were the most reported ones and the groups of people in the catchments area were mostly clerics (n=49; 51%), families (n=30; 31%), elders (n=27; 28%) and mosque's-imam (n=21; 22%). Most reported reasons were the consideration of it is a sin (n=68; 70%) and the perception that it is against Islamic principles and that it promotes western agenda.

Problems of accessibility were also reported by (n=21; 22%) the LHWs and they reported that marginalised groups existed in their catchments areas. Mostly these were the ethnic Pathans (n=20; 21%) who do not allow FP counselling in their homes due to their social and cultural values.

Of the respondents 66 (68.44%) said that misconception about different methods of FP still existed in

their communities though it was higher in the past. Misconceptions are more about surgeries (tubal ligation) (n=81; 83.8%) and intra-uterine contraceptive devices (IUCDs) (n=68; 70.3%).

Half of the respondents (n=49; 48%) were facing problems in promoting FP as they had to repeatedly and continuously deal with first-time clients. Some women (n=21; 25.5%) had to take permission from their husbands.

More than two-third (n=68; 72.3%) CBAs had apprehensions about the use of modern FP methods. Two-third (n=64; 66%) fears were due to unforeseen side effects and complications. The fear was more for surgeries and IUCDs because complications arise later on and the women start telling other women about their experience, creating problems for FP adoption.

Of the respondents, 84 (87%) of the LHWs were referring FP clients to various health facilities; mostly to their attached health facility (n=56; 58%), followed by RHCs (n=55; 57.5%), Taluka Headquarter Hospital (n=15; 16.20%), and Divisional Headquarter Hospital (n=9; 9.90%) or to the Population Welfare Centre which was usually on camp days. They also referred the first timers to the doctor or the Lady Health Visitor (LHV) to rule out any complication or contraindication. They also referred clients with complications and usually accompanied the client up to the centre. Mostly the referred clients were facing transport problem, especially on camp days. They had to wait for long hours for their turn. Some also reported inappropriate attitude of the staff, insufficient arrangement and payment for the procedure, resulting in the reluctance of clients going again.

Half of the respondents (n=48; 50%) reported stockouts and deficient supply, especially of injectable contraceptive, of medicines nearing expiry. Other barriers were previous reported complications (n=46; 47%), lack of education/awareness (n=47; 47%), family pressure (n=32; 33%), and technical skill (n=31; 31%).

To overcome resistance, LHWs were using different strategies (Figure-2). The majority were using LHS help (n=52; 54%) and they were repeatedly explaining via literature promotional materials also; nevertheless they were referring clients to LHVs but only (n=19; 20%) were using this help. The majority were using the help of existing health committees 71 (73.9%) and support groups in the catchment area 50 (52.3%).

To overcome or reduce the barriers, the respondents also gave different suggestions (Figure-3). The majority demanded more incentives 60 (62%), enhancement of the role of the existing health committees 64 (67%), proper arrangement for the referred clients 60 (62%), especially on camp days, and for the generation of more awareness in the public via electronic and print media 72 (75%).

Discussion

LHWs consider FP as part of their job description and play a major role in record-keeping, most importantly of eligible couples and other FP clients in their respective areas. They are promoting modern contraceptive methods except transdermal patches. They were found to have good knowledge of FP concepts and considered important factors before starting FP. Barriers were more in the past - 15 years back - when the programme first started and they had now mellowed down. Socio-demographic variations were also recorded, like in our study the mean age was 36 ± 7.72 years; a little higher than 2008 Oxford Policy Management (OFM) and 2000 Reports, where it was 32 and 29.6 years respectively. Similarly, married LHWs were 76%, while OFM figures were 66% in 2008 and 62% in 2000.

The clients in the catchment areas of the LHWs were using condoms, tubal ligation, IUCDs, injections, oral pills and male sterilisation in the same order. This was in contrast to the PDHS Survey, 2007, wherein the most frequent modern contraceptive method being practised was tubal ligation followed by condoms and injectable contraceptives. However, the use of pills, IUCDs and male sterilisation was similar to the methods used in our area of study. Though the oral contraceptive pills are available in abundance with the LHWs, the clients did not like it because of side effects.

According to the LHWs, 90% of the clients know about all FP methods, while the PDHS, 2007, showed that 96% of the clients had knowledge about FP. In a study in Vietnam, lack of knowledge of contraceptives was realised as a barrier.¹⁷ LHWs were also explaining the mechanism to the clients that how contraceptives could stop prevent pregnancy and one-fifth was facing problems in explaining these methods.

In our study, major barriers were religious in nature. These were reported more in some groups like clerics, imam of mosques, hafiz etc. The most common reason was their perception that FP was a sin and against Islamic principles. Socio-cultural barriers were mostly excessive domestic work, or family resistance. Mother-in-law was a big barrier to the LHWs, followed by sister-in-law. Husband's permission was also a hindrance. Presence of ethnic groups like Pathans and people living in shelter homes were also reported as creating problems of access in their catchment areas.

Majority of the LHWs said that they were maintaining privacy during FP counselling to overcome such barriers. Similar findings were reported in a study in eastern Azerbaijan and Iran¹⁸ and it was found that maintaining privacy, confidentiality and communication were necessary components for FP.

More than two-third of the respondents said in the

current study that still misconceptions regarding FP persist in the community, though less than in the past. These findings are similar to the findings of studies^{19,20} that have reported that using modern contraceptives would cause infertility. This was also a finding in our study. However, other misconceptions were reported more which included menstrual irregularities, cancers or ominous effects on other children. Menstrual irregularities were also found to be a barrier for hormonal contraceptives in a study from Nigeria.²¹

LHWs were using multi-faceted strategies to overcome resistance. To improve FP usage, different suggestions were given by the LHWs, like sufficient reward for their services, awareness generation etc.

In terms of limitation, the study, being cross-sectional in nature, could not determine the cause-and-effect relationship among the variables studied.

Conclusion

The study revealed that LHWs still faced barriers at individual, community and system level for the delivery of modern FP methods. Misconceptions exist in the community about different FP methods and the LHWs use different strategies to overcome these problems.

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