Original Article

Unmet Need and Nonacceptance of Usage of Contraceptive Devices in a Rural Area of Delhi: An Exploration of Facts

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Abstract

Background: An important cause of high fertility rates in Delhi is the low availability and use of family planning services. Fostering family planning practice alleviates poverty, accelerates socioeconomic development, increases child schooling, promotes gender equality, and decreases maternal and infant mortality. The study objective was to find out the perception of potential users, health workers, and health professionals on the reasons for nonusage of contraceptive services provided and to recognize possible solutions to the identified barriers. **Methods:** This cross-sectional study was done using qualitative methods among three groups of people by focus group discussion and in-depth interviews. The study was conducted in the rural health center of Madanpur Khaddar, Department of Community Medicine, Jamia Hamdard Institute of Medical Sciences and Research, from June to August 2016. **Results:** The median age group of the participants was 27 years, and the participants were majorily less educated and were homemakers. Description of key thematic issues found out that contraceptive nonusage was due to lack of accessibility, lack of availability, as well as issues with privacy and autonomy. Out of 25 women, 3 had never heard the term Copper-T (CuT). Twelve out of the rest 22 women had heard about CuT, but knew no more than that. **Conclusion:** The findings that have emerged from this study thus provide some recommendations to increase the demand for contraception. Effective information, education, and communication should be promoted continuously with the help of community health workers for better acceptance of CuT because it is believed that no single child should be born into the world unplanned.

Keywords: Contraception, family planning services, unmet need for contraception

Introduction

Worldwide, there is a growing consensus that a good approach to family planning would help in achieving the Millennium Development Goals.[1,2] Fostering family planning practice alleviates poverty, accelerates socioeconomic development, increases child schooling, promotes gender equality, and decreases maternal and infant mortality.[3]

The National Family Planning Program since its inception has been dominated by demographic goals. The program focused primarily on sterilization, largely obviating client choice and limiting availability to a narrow range of services. In October 1997, India reoriented the national program and radically shifted its approach to more broadly addressed health and family limitation needs.[4]

Globally, the prevalence of contraceptive use has been increasing, but the unmet need for contraception still remains a problem. According to the National Family Health Survey-3 (NFHS-3), the national figure for unmet need is 13%. According to the District Level Household and Facility Survey-3, the unmet need of contraception in India is 21.3%, with 7.9% for spacing and 13.4% for limiting births. The unmet need for contraception in Delhi is about 13.9%, out of which 3.8% is for spacing and 10.1% is for limiting family size.[5,6]

The NFHS-2 reveals that 16% of women in the country have an unmet need for family planning.[5] Some of the reasons for unmet needs for family planning are lack of appropriate family planning and motivational services in the area, lack of knowledge, and disapproval by one of the partners or family members. Our interaction with women in the community revealed that, though people have understood the importance

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Access this article online

Quick Response Code:

Website: www.nigeriamedj.com

DOI: 10.4103/nmj.NMJ_9_17

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How to cite this article: Panda M, Pathak R, Rasheed N, Shaikh Z, Islam F. Unmet need and nonacceptance of usage of contraceptive devices in a Rural Area of Delhi: An exploration of facts. Niger Med J 2018;59:39-42.

of small family size and have understood its repercussions on them and on the community as a whole, they are reluctant to accept and use certain contraceptives for their own benefit. This observation made during field experience by the author as a clinical practitioner has prompted the need to assess the factors underlying the nonacceptance of contraceptives among rural women. Besides the potential users, the perspectives of medical professionals and health workers were also reviewed in parallel to get a comparative overview of these perspectives on key thematic issues. This would provide a balanced feedback from all stakeholders on this subject.

Methods

This was a cross-sectional study using qualitative methods among three groups of people who were recruited using a convenient sampling technique. The rural health center in Madanpur Khadar attached to the Department of Community Medicine, Jamia Hamdard Institute of Medical Sciences and Research, was chosen for conducting the survey. It caters to a population of 120,000. The first group in the study comprised women of reproductive age (WRA), who were conveniently chosen from the village for focus group discussion (FGD) and in-depth interviews (IDIs). The second group comprised community-level health workers, including medical social workers, health educators, Anganwadi workers, and health inspectors attached to the community or working in collaboration with a nongovernmental organization in the rural health training center. There were a total of ten community health workers during the survey, and they all gave consent to participate in the group discussion. The third group was selected by a closed fish bowl technique with a total of thirty participants; six participants were drawn each time from the center by rotation. This comprised 22 students from MBBS; nursing and paramedics were chosen by a purposive sampling with uniform representation from all batches and grades as depicted in Table 1. The rest of the eight participants were drawn from the Department of Community Medicine.

Data collection was followed by analysis for which the grounded theory was used to sum up the collected data. Atlas Ti software was used, and ultimately representation was done using the thematic framework approach. Privacy was ensured while conducting interviews. Confidentiality and anonymity was maintained during the procedure. Informed consent was obtained from the participants. Participation was purely voluntary. Necessary ethical approval was collected, and there was no conflict of interest.

Results

The participants were largely less educated and were homemakers, with a median age of 27 years this is depicted under the sociodemographic details in Table 2.

Metric level is education up to class 10.

Findings of IDIs of WRA group and FGDs among WRA, health workers, and professionals were summed up as depicted in Table 3. We chose certain common key thematic issues and noted down the summarized views of different stakeholders as follows:

Quotes:

- Respondent no. 5: "My husband does not recommend CuT, so I cannot use it"
- Respondent no. 8: "I feel shy and bad to talk about this secret issue with someone else other than my husband"
- Respondent no. 15: "I don't know whether other women are using it or not, so I do not discuss it with anyone else"
- Respondent no. 19: "I thought that it was an operative procedure and as health worker is senior to me in age, I felt shy to ask her in detail about CuT."

Discussion

This study was conducted to explore the perception of women about contraceptive device usage, why they prefer certain type of contraceptives, whether the low acceptance is due to unavoidable encroachment on women's privacy, what are the barriers they face, and what challenges and hindrance are faced by health-care workers in delivering contraceptive services.

In rural areas, few women were not aware of certain contraceptive methods, so they never demand this service from health-care providers. Most of the women thought that

Table 1: Description of the study participants and study objectives

Study objective	Study participants	Description
Find out perception of the beneficiaries about the contraceptive services being provided to them	Married women of age group 15-49 years	Married women of age group 15-49 years of the rural area in Madanpur Khadar village, at the RHTC under HIMSR, were taken up for the study from June to August 2016 using a semi-structured questionnaire, four FGDs of six members each and IDIs of 25 participants of different ethnic groups
Learn about the pros and cons of the services provided, as experienced by the service providers	MSWs, HI, HE, and AWW	All the MSWs and HEs attached to the health center along with AWW under the NGOs attached with the RHTC were called up and were made a part of a FGDs
To explore the challenges and come up with possible solutions	Students and professionals in health care	Thirty participants including students and faculties were included in the group discussion by a closed fish bowl technique

MSWs – Medical social workers, HE – Health educator, HI – Health inspector, AWW – Anganwadi worker, NGOs – Nongovernmental organizations, RHTC – Rural health training center, FGDs – Focus group discussions, IDIs – In-depth interviews, HIMSR – Hamdard Institute of Medical Sciences and Research

contraception means usage of pills. Out of 25 women, 3 had never heard the term Copper-T (CuT). Twelve out of the rest of the 22 women had heard about CuT but knew no more than that. This indicates a gap in the required knowledge and reason they fail to demand, as well as nonacceptance of the method. There are no information, education and communication (IEC) programs to increase awareness about the various types of contraceptive methods in the community as noted by the health-care workers in FGDs. An operational research study done in Gujarat by frontiers in Reproductive Health Programme of the Population Council using a pre- and post-intervention design stressed the importance of IEC, which improved clients' performance after the intervention.[7,8]

Table 2: Sociodemographic profile of the study participants

Characteristics	Values	Frequency (%)
Age (years)	<25	9 (36)
	25-35	14 (56)
	>35	2 (8)
Education	Below metric	12 (48)
	Metric and above	13 (52)
Occupation	Working	3 (12)
	Homemaker	22 (88)
Income per month	<5000	13 (52)
	>5000	12 (48)
Religion	Islam	10 (40)
	Hinduism	15 (60)
Caste	General	8 (32)
	OBC	12 (48)
	SC/ST	6 (24)

From among the few women who knew about intrauterine contraceptive devices in detail, all had the fear of side effects. They had less perceived benefits of CuT and more perceived benefits of oral pills. This might be due to the differential dissemination of information by health-care providers. Moreover, the women narrated that the health-care workers motivated them more about sterilization methods and contraceptive pills. Insertion of intrauterine devices (IUDs) requires skill, expertise, and confidence; the lack of such skills by the health-care workers might be one of the reasons they are less motivated to counsel clients on its use. A study by Rati *et al*. and Murarkar *et al*. mentioned that inadequate knowledge of women regarding contraceptives leads to myths and misconceptions, resulting in the nonacceptance of IUD as a spacing method.[9,10]

Rural women are less concerned about the hygiene of their genital tract, and most of them have pelvic inflammatory diseases (PIDs), which makes them unfit as candidates for IUDs.[11] Moreover, follow-up is seen as an additional burden by females because of time constraints and family engagements. Some women quoted that health workers could not ascertain the time of their last deliveries because of long intervals. Variation of autonomy in selection arises due to the ignorance of homemakers, dominant nature of husbands

Table 3: Summary of focus group discussion and in-depth interviews, based on key thematic issues

Thematic issues	WRA group	Community health workers	Health professionals
Accessibility	Inhibition and embarrassment to discuss about the methods Health centers are far off and are usually open in morning time, when they are busy with their household activities	In some cases, the head of family does not permit the daughter-in-law to meet health-care workers in private or talk to them	Beneficiaries should be comfortable with the person who is distributing the contraceptives. Outlets for distribution can be opened up at convenient places A day can be fixed up in a week which would specifically pertain to family planning services
Availability	Nearby health centers though equipped for IUD services do not have trained staffs	MSWs say that when contraceptives are given free, beneficiaries do not take it, assuming it to be the discarded ones which are being phased off	Availability and accessibility are inter-related. First it should be made universally available as a basket of choice so that people can access it easily
Autonomy and privacy	Want freedom of getting oral pills from shops not depending on any community health worker Family planning components are dealt by their husbands who do not like being counseled by female workers	Women like to preserve their autonomy and privacy They feel ashamed to talk all these in front of their mothers-in-law, or children, who accompany them everywhere	If the mother-in-law or the husband is motivated, they can help the woman in reaching out for the IUDs as well as maintain privacy
Misconception	Pills will make us obese and cause vomiting and adverse reactions, What if I forget? Will make me weak	Women feel that it causes too much of side effects in them	Gradual approach should be undertaken to change, enforce, and practice positive attitude
Awareness and knowledge	Illiteracy and social distance are reasons Differential dissemination of information also causes a lack of initiative	Women are aware but not as much as they need to There are no much IEC and BCC programs running from government side to let them know	Government initiatives to educate both service providers and getters

WRA – Women of reproductive age, IUDs – Intrauterine devices, CuT – Copper T, IEC – Information, education and communication, BCC – Behavior change communication

and mothers-in-law in the society, fear of being exposed, and lack of privacy. Similar result was seen in the study by Yadav *et al*. which was regarding the reproductive intentions and contraception between husbands and wives in rural Ballabgarh, India.[11]

Almost all health workers admitted that the women did not trust them, so they never took their advice serious. Women of low income and low literacy status often feel that it is a credit to them to manage spacing between pregnancies on their own without using any contraception. These women either use calendar method or withdrawal method. Muslim women do not like to use contraceptive methods except some who use withdrawal technique and oral pills. They confidently declare that their religion does not allow them to do so. Few adverse experiences from peer groups serve as a source of propaganda such that community health workers are unable to persuade them to use such contraceptive methods.

Conclusion

Because of the demotivating facts, the demand from the acceptors' side dwindles and becomes less. The success stories become less than the failure stories, and hence, propagandas take the troll. The findings that have emerged from this study thus provide some recommendations to increase the demand. Effective IEC should be promoted continuously with the help of community health-care workers for better acceptance of IUDs. Because the most important constraint as regards to beneficiaries is their time and family workload, the best practical solution for checking eligibility of the candidate to be fit for CuT insertion is to do a house-to-house visit, report finding of any PID symptoms if any, get it treated, and then call her up for the intervention, rather than blindly calling everyone every time and then returning few because they were not fit for it. A team effort with collaboration and cooperation of various sectors and departments will help us in defining the vision and mission more accurately.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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