PULSE
UPDATING YOU ON HEALTH DEVELOPMENTS

5. BARRIERS TO ACCESSING FAMILY PLANNING SERVICES

FAMILY PLANNING USE IS STAGNATING

The Access to Health Services Study (Thomas et al. 2012) identified barriers that poor and excluded people face to use family planning (see Table 1). These barriers are linked to socio-cultural and religious beliefs, the fear of side effects, gender-based barriers, and service-related factors. Addressing these barriers is critical for increasing demand for and access to family planning.

The findings from this study are particularly important given that the Nepal Demographic Health Survey (MoHP et al. 2012) recorded a slight decrease in the contraceptive prevalence rate (from 44% in 2006 to 43% in 2011) and an increase in the unmet need for family planning (from 25% to 27%).

SOCIO-CULTURAL AND RELIGIOUS BELIEFS

The study found that social, cultural, and religious beliefs strongly impact access to health services including family planning, and contribute to gender and social exclusion.

The almost universal preference for sons among participants significantly limits the uptake of family planning and results in reluctance to use any method until at least one son is born. Men without sons were reported to be discriminated against, by being excluded from social events and public gatherings, meetings, and financial loans from community members. Married couples without sons were said to be stigmatised and referred to by derogatory terms.

THE ACCESS TO HEALTH SERVICES STUDY

A study was carried out in 2012 to understand the socio-cultural, economic and institutional barriers that poor and excluded people face accessing health services in Nepal. It used the rapid participatory ethnographic evaluation and research (rapid PEER) method, which is designed to explore sensitive issues with non- and low literate marginalised populations. Rapid PEER interviews happen in the third person to avoid response biases and are carried out by 'ordinary' members of target groups to elicit frank responses. The study examined experiences of accessing essential health care services at sub-health posts, health posts and outreach clinics.

Six social groups were studied: Chepangs, Muslims, Madhesi Dalits, Other Backward Classes (OBCs or other Madhesi castes), hill Dalits, and poor hill Chhetris and Brahmins, thus covering caste, ethnic, and religious differences. Each group was studied in two districts giving 12 sub-studies with 374 interviews in all.

Eight briefing notes have been produced to disseminate the findings. Note 1 gives the background and methodology while notes 2, 3 and 4 present the findings on the effects on accessing health care of poverty, caste and ethnicity (2); gender (3) and geography (4). Note 5 presents the findings on access to family planning, note 6 on access to safe abortions, note 7 on access to maternal health services and note 8 on access to child immunisation services. The study report (Thomas et al. 2012) is available at http://www.nhssp.org.np/gesi/Nepal%20PEER%20Revised%20Report.pdf

In some study areas, a single male child was said to be insufficient. The rationale is that infant mortality is perceived as high and male children bring future financial security and respect from society. This leads to multiple pregnancies regardless of the number of daughters a couple have or the effects of multiple pregnancies on a woman's health.

"It is difficult to take family planning services because there is the saying 'one son is not a son' and, as one ox cannot pull the plough, two oxen are required to pull the plough. When a couple have a son, the son is for them. But the daughters will go to another's home in the future. In our community two sons are necessary; one is not enough. They believe that more sons will earn more money."

Female, Doti

Figure 1: Perceived disadvantages associated with family planning methods

Family planning method	Type	Perceived disadvantages and side-effects	Who is affected
Oral contraception pills	Temporary short-term	• Weakness and sickness • Increased weight • Excessive bleeding • Changes to menstrual cycle • Increased risk of infidelity/adultery • Increased distrust within marriages	Women
Injectable contraception (Depo-Provera)	Temporary long-term		
Contraceptive implants (Norplant)	Temporary long-term		
Intrauterine contraceptive device (IUCD) (Copper T)	Temporary short-term	• Pain during and after fitting	Women
Condoms	Temporary short-term	• Breakages • Get stuck inside women causing abdominal and pelvic pain • Spread diseases • Reduced sexual pleasure for men	Men and women
Sterilisation	Permanent	• Physical weakness • Abdominal and back pain • Risk of sexual infidelity	Women
Sterilisation (vasectomies)	Permanent	• Physical weakness causing inability to work • Risk of sexual infidelity • Religious impurity (Hindus) • Forbidden by scripture (Muslims)	Men

Religious beliefs that promote childbirth often prevent the use of family planning. Study participants explained that children are a gift from God and so becoming pregnant is seen as a blessing. Some participants believed that family planning should not be used as it inhibits what naturally happens through sexual intercourse.

Muslim participants strongly believed that their scriptures forbid vasectomy and temporary family planning methods. Among Hindus, male vasectomy was said to be discouraged as it is believed to lead to impurity and exclusion from rituals such as 'shraddha' (the lighting of [usually a parent's] funeral pyre) and to physical weakness that impacts men's ability to earn a living.

The study found a common belief and trust in spiritual healing among Chepang participants. Their traditional healers prescribed the use of certain herbs for family planning.

Many participants expressed strong concerns that longer-term temporary and permanent methods encouraged infidelity. Husbands and wives worried that the use of these methods gave freedom to have sex without consequences and encouraged adultery.

Women who wished to use family planning services were said to risk being gossiped about and feared being accused of having sexual relationships outside marriage. This was particularly so in Madhesi communities as a result of the close proximity of homes in their villages, stricter social controls, more gender discrimination and less women's participation in decision making (MoHP et al. 2012).

"If a man has permanent sterilisation, it is feared he will have illicit relations. If women have permanent contraception, they are accused of being conceited and having relationships with other men. And if husbands go for a permanent method, wives will not get enjoyment and will have sexual relations with other men."

Female, Makawanpur

Male participants from the hills and Tarai who showed willingness to use family planning methods, or supported their wives at health check-ups, were said to be targets of gossip by local people, thus discouraging the use of family planning.

SIDE EFFECTS

Stories about side effects spread rapidly and feed perceptions that family planning methods threaten individuals' and couples' physical and emotional well-being.

The study found that condoms were perceived badly. There were stories about them splitting, getting stuck inside women and causing illness in the pelvis and abdomen. It was said that if they leaked during intercourse, resulting in a pregnancy, then

the women would be suspected of infidelity. Rumours were also reported that condoms spread disease, and so they are sometimes stigmatised as 'disgusting'. The use of condoms was also said to reduce sexual enjoyment for men.

A major concern with permanent family planning methods was that men and women would be unable to work to their full capacity after such operations. Thus the study found that women discouraged men from having vasectomies for fear it would undermine their performance as bread winners. Equally, stories of women becoming ill and weak after a mini-laparotomy discourage the use of this permanent method for fear of women being unable to carry out their domestic duties.

"The pills cause weight loss and dry the body. Depo swells the body with water. Copper T later causes pain, so many women don't use family planning methods; and even their husbands don't let them use them and say that if you become ill after using contraceptives, we will not treat you."

Female, Banke

GENDER MATTERS IN THE HOME, IN COMMUNITIES, AND AT FACILITIES

Gendered beliefs and norms affect family planning decision-making. Most women were said to need permission from their husbands and elders to use family planning and to visit health facilities for supplies and services. Women's heavy domestic and work burdens, especially in hill rural areas, leave them short of time to avail of services, especially when opening times and availability of health staff are often unpredictable. In the Tarai, traditional and discriminatory social norms restrict women from using family planning. Without control over resources or cash, women depend on their husbands and parents-in-law for money to access family planning services, and face the threat of punishment if they try to access services without permission.

Strict controls on mobility and use of public spaces apply to women from all backgrounds as families seek to maintain prestige by following cultural and religious beliefs and keeping women at home. Fears of infidelity and gossip when women transgress norms also constrain women's mobility. The result is that almost all women were said to need accompanying to a facility by a family member, with consequent opportunity costs and impacts on women's willingness to seek care.

Lack of same-sex health personnel was also said to be a major deterrent to women and men accessing family planning methods. They feel shy to discuss something so personal with staff of the opposite sex, and women feel especially shy to undergo physical examinations by male health staff. This was particularly pronounced amongst Muslim women and women from Other Backward Classes, and for newly married women. Women were said to often be too shy to ask for IUCDs to be fitted because of the invasive nature of the fitting and concerns that the procedure may be carried out by a male doctor. Men reported feeling shy asking female community health volunteers (FCHVs) for condoms. The lack of locally available staff with the skills to provide IUCDs and implants was also reported as barrier.

A 32 year old Dalit woman from Dailekh with her twelth child. She has been bypassed by family planning services

"When a woman goes out alone, although the family members might not have any problems, village males will backbite and suspect her. They say that her character is no good. When the husband hears these things about his wife, he won't allow her to go outside."

Female, Banke

"Men do not use condoms for fear they will break. So, men have their women use the injection [Depo-Provera]. We men also feel shy to ask for condoms as there often are only female staff (in the health facility)"

Male, Dhading

POVERTY, CASTE AND ETHNICITY OBSTACLES

Poverty is a major determinant of access to primary health services across social backgrounds. Caste and ethnicity can add a further dimension of vulnerability. Caste-based discrimination was reported by Madhesi and hill Dalits with Madhesi Dalits saying they suffered more discrimination at health facilities and within society. Caste discrimination was said to be experienced by service seekers in three ways:

- *Lack of access to care:* Outreach services, such as home visits by FCHVs, were reported to be withheld from Dalit patients but provided to other caste groups.
- *Delayed access to care*: Dalits from hill and Tarai areas reported often having to wait longer than others at health facilities, often being treated last, and as a result, often returning home without being treated.
- *Poor quality care:* The reluctance by service providers to have physical contact with Madhesi Dalits was said to lead to fewer physical examinations, and to reflect discourteous behaviour.

Discriminatory practices towards Madhesi Dalits by other community members, compounded with family pressures on women not to seek care, are exacerbated by the challenges of reaching services. Continuing social exclusion also results in frequent self-exclusion as families avoid potential discrimination and do not believe they can afford quality care.

"The health workers treat non-Dalit women well and do their check-ups immediately. But they don't treat Dalits and uneducated women well. They don't touch us."

Female, Saptari

"Women from low castes like Chinimara, Rawatik and Kushbandhi fear to talk to the doctor. The doctor sends them away, scolding them and treating them badly. If we don't reach the facility on time, they don't do a check-up after 1pm, and the health workers even scold us.

Female, Banke

QUALITY FAMILY PLANNING SERVICES NEED TO BE LOCALLY AVAILABLE

Women's lack of decision making autonomy, lack of cash, and restrictions on their public actions, makes them depend on others to seek care and organise the logistics of reaching services. Bringing family planning services closer to poor rural women and men will help address the social constraints placed on women's mobility and enable women to access services covertly. This will also reduce the costs of reaching facilities and the time people have to spend away from home and work. The regular provision of temporary methods by skilled health providers and FCHVs, and health camps providing contraceptive services that are unavailable at local health facilities, will help women overcome the barriers they face reaching distant health facilities.

In 2011, only 13% of health posts had at least five family planning methods available

Suvedi et al. 2012

ISSUES TO CONSIDER

1. How to improve the quality of peripheral health services that many poor women and men have greatest access to?

2. How to build the capacity of health workers, strengthen community outreach and community mobilisation, and deliver more behaviour change communication programmes to address the socio-cultural and other barriers to accessing family planning?

3. Can targeted communication be developed based on local contexts to address the many reasons why couples do not use family planning methods including lack of information, concern over side-effects, lack of availability of services and social pressures? Messages and tools need targeting to different audiences. This may involve interpersonal communications in homes; getting satisfied clients and couples to share their experiences via mothers' groups, women's groups, and community events; and using spiritual healers and imams (Muslim leaders) as communication agents.

4. What can government agencies, in partnership with local NGOs, do to encourage the hiring of male motivators to inform men about the use of family planning methods and to change men's attitudes towards women's use of the different types of contraception?

5. What can be done to address the specific barriers Muslims face to using family planning?

6. How to strengthen the monitoring of communication activities and the uptake of services; identify underserved communities; and through consultations with communities, develop interventions to improve access.

7. Can auxiliary nurse-midwives be trained to deliver IUCDs and Norplant (with appropriate supervision and support) and can health providers' counselling skills be improved to motivate couples and provide post-family planning acceptance advice? The aim is to provide quality services closer to communities at health posts, sub-health posts and outreach clinics.

8. How to provide improved services at family planning camps, including counselling couples before and after acceptance?

9. Can a voucher system be introduced for sterilisation clients to cover their transport, food and rest costs?

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