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USE OF CONTRACEPTIVE METHODS AMONG MARRIED WOMEN OF BAGNIBARI VILLAGE: PERCEPTIONS, PREFERENCES AND BEHAVIORS

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ABSTRACT

Introduction: Understanding the cultural and socioeconomic factors influencing the choice of contraceptives among women are essential to having a successful family planning program.

Objectives: To identify the cultural and socioeconomic factors influencing the individual use of contraception among married women of reproductive age in Bagnibari village

Methods: A qualitative grounded theory approach collected data from In-Depth Interviews (IDI), a Focus Group Discussion (FGD), Participatory Rural Appraisals (PRA), and informal discussions and observations in peri-urban Bagnibari village from married women of reproductive age and key informants.

Results: The most popular contraceptive method is the pill followed by the injection. Decision-making regarding contraceptive use is directly and indirectly affected by the relationship of three dimensions – individual, cultural, and socioeconomic. All are heavily influenced by Muslim religious beliefs and male and female power dynamics. Women are responsible for use of contraceptives and often do not have proper knowledge regarding the methods and side effects. Knowledge is further limited by the cultural context placing women primarily in the home without access to non-governmental family planning options. Women perceive government family planning as inadequate. There was a lack of trust in government services. Women prefer temporary methods rather than permanent methods owing to their religious beliefs.

Conclusion: Cultural and socioeconomic factors have a significant impact on contraceptive use. The relationship among the three dimensions influencing contraceptive use has to be addressed when delivering family planning services.

Key words: contraceptive use, cultural, socioeconomic, preference, perception

I. INTRODUCTION

Family planning programs have been present in Bangladesh for more than three decades. These programs have had a significant impact in addressing the undesirably high Total Fertility Rate (TFR) of the country since it gained independence in 1971. Historically, a consistent increase in the Contraceptive Prevalence Rate (CPR) has helped to decrease the TFR from 6.9% in 1970 to 2.3 in 2008 (UNICEF, 2010). However, the CPR began to plateau in the 1990s for about ten years, resumed growth for a while and continued to decline from 58% in 2004 to 56% in 2007 (Bangladesh DHS,

2007). Addressing the current cultural and socioeconomic barriers influencing contraceptive use will assist Bangladesh in its continued efforts to decrease the TFR. Control of population growth in the world's most densely populated country needs to persist through family planning programs to continue the decline in fertility and increase economic development (CIA Factbook, 2009).

Bangladesh is home to one of the largest populations of Muslims in the world, having a predominantly agricultural based economy. Half of the population is currently living under the international poverty line with the women comprising a miniscule eight percent of the workforce and little decision making power (Boonstra, 2001).Thus, the relatively universal cultural and socioeconomic factors influencing the use of contraceptives need to be addressed in the Family Planning (FP) program at a national level. The following factors have noteworthy roles in contraceptive method choice: cultural preference, different levels of effectiveness, convenience, accessibility, and suitability for a couple (Mannan, 2002).

Kamal (2000) found that the most significant factor influencing the current use of modern contraceptive methods among women in Bangladesh is "husband's approval" of family planning (Kamal, 2000). Perception of contraceptives is therefore critical in identifying how to address the differing needs among women to increase the CPR. In a traditional society like Bangladesh when a woman is expected "to be guided by their husband's opinion in every sphere of life", women may not receive essential reproductive health care (Kamal, 2000). The situation is further aggravated when it comes to women with little or no education and using contraceptives. As Obermeyer (1999) stated, "discrepancies have repeatedly been found between women's perceptions and expressions of their needs and biomedical assessments of their health" (1999). Thus, it is important to gain an understanding of their perspectives if the Bangladeshi government is to deliver a family planning program that will be utilized efficiently.

To gain as much insight available on the perceptions regarding contraceptive use it is necessary to use qualitative studies to find these answers.

This paper reports the findings obtained from a qualitative study during March 2010, in Bagnibari village, a peri-urban area of the Dhaka division. The purpose of the study was to identify the cultural and socioeconomic factors influencing the individual use of contraception among married women of reproductive age in Bagnibari village.

History

In the mid-1970s, the Bangladesh government initially introduced FP programs empowering women to make decisions regarding their reproductive health. The CPR during this time was less than 10% (Saha, 2007). The government established more satellite clinics, advocacy at the community level by key informants (e.g., religious leaders) to raise awareness, giving incentives for using permanent methods. Initial FP services offered invasive options, such as the Intra Uterine Device (IUD), tubectomy, and vasectomy. In 1978, the government began to distribute the contraceptive pills free of charge throughthe Family Planning Workers (FPW) who were visiting the women door-to-door in their houses (Kamal, 2000). The introduction of the pill as a contraceptive method was not initially accepted. In fact it took a long time to increase the rate of usage only from 5% in 1985 to 21% in 1996-97 (Mannan, 2002). This increased rate also signals a transition from more permanent contraceptive methods to modern temporary methods (e.g., pill, injectables, condoms).The transition to a modern contraceptive market is likely the result of the significant changes in the cultural and socio-economic situations from Bangladesh's independence in 1971. This resulted in the introduction of new preferences, perceptions, and behaviors influencing the use of contraceptives. For example, the perception of family size, the changing socio-economic status of the population and the improvement in education of women in post-independence Bangladesh.

Quantitative studies since FP programs were first introduced in the mid-1970s and at present have revealed the trends in the CPR, but survey limitations fail to address the cultural and socio-economic factors that influence the choice of methods. The few available qualitative studies focusing on the influences on contraception method choice are outdated and emphasize only one factor, such as power relations, but not the combination of factors influencing the choice of contraceptive methods.

In that regard, acontemporary qualitative study based on grounded theory will contribute to a greater understanding of the cultural and socio-economic factors influencing method choice among married women of reproductive age currently in Bangladesh.

II. METHODOLOGY

The study was conducted in the peri-urban area of Bagnibari, about 30 km outside the center of Dhaka city. Village population is 7,000 people within 530 households having 700 eligible couples of reproductive age (Union Office Worker, personal communication, March 9, 2010). The village livelihood is mainly agriculture, but many garment and furniture factories near the village provide additional job opportunities. In addition, most houses have generous land plots, brick-built houses, access to clean water, electricity, and livestock (e.g., cattle, goats, chickens). Bagnibari village is within Birulia union sharing a Family Welfare Centre (FWC) provided through government family planning services that employ FPWs responsible for the home-delivery of pills, injectables, and condoms.

B. Study Design, Sampling & Methods

From existing literature and our personal experiences, the study was designed by conceptualizing contraceptive use within three domains – individual, cultural, and socio-economic. The individual level may include the woman's age, occupation, education, present children (e.g., number, age, and sex), contraceptive side effects, knowledge and preference. The cultural dimension reflects the dominating practice of the Muslim religion, the power dynamics between men and women in Bangladesh, son preference, and a general lack of empowerment. The third dimension focuses on the socio-economic factors including income, occupation, contraceptive cost, government service, and accessibility of sources.

Data were collected through six in-depth interviews with married women of reproductive age and one FPW, two Participatory Rural Appraisals (body mapping and free-listing), one Focus Group Discussion (FGD), informal observations and discussions with key informants using semi-structured guidelines. In addition, an extensive literature review provided insight on past and current usage of contraceptives as well as the cultural and socio-economic context.

Based on research questions, we designed certain criteria for our sample selection using a small sample size to address our research efficiently and collect data of great depth and breadth. Village households were chosen conveniently throughout different areas of the village with the purpose of locating married women of reproductive age. Thus, initially our sampling was purposive, but later we also chose our sample conveniently because of our field time restriction. Most data were collected from the local pharmacy, the union health complex, a medicine shop, and village households from males and females. However, we initially started collecting our data from the married women of reproductive age until the women informed us their primary source of contraceptives were from the pharmacy and local medicine shop.

C. Data Analysis& Ethical Considerations

Transcripts were completed cohesively among the three research analysts the day the data was collected. All qualitative data collected were analyzed using the same broad coding process of general themes and specific sub-categories. The analysts independently coded the transcripts and discussed the codes collectively to assign final codes in agreement, adding rigor to findings. Accuracy of data was ensured through triangulation of data collection methods involving different key informants. Final codes were all cross-referenced to ensure validity. Manual coding was used to familiarize the analysts with the data and the emerging themes. Each code was identified on a separate note card and as a team the analysts maneuvered the codes in a multitude of combinations in an open floor space until themes began to emerge. Analysis of the data ceased after it was reflected on and reanalyzed numerous times until significant relationships among various factors emerged and emphasized the most significant findings.

Ethical considerations were taken into account via informed verbal consent explaining the study purpose. Participants were assured of confidentiality. The willingness of participation or refusal in the study and the ability to withdraw at any time was explained. In addition, each participant was given a pseudonym.

III. FINDINGS

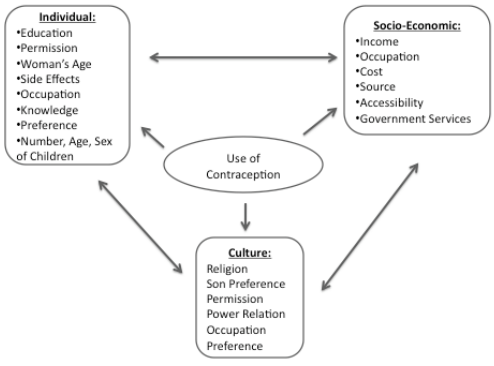
A. Contraceptive Use

The general use of contraception was examined using in-depth interviews and FGD. Of the 16 female participants of Bagnibari village, 14 were using family planning methods. Of the two non-users, one woman and her husband wanted one more child. The contraceptive pill was the most popular method among women: 10 women used the contraceptive pill, 3 women used the injection, and 1 used condoms. Women had knowledge of other contraceptive methods (e.g., IUD, Norplant, sterilization), but none were users and commented that those were not popular methods in Bagnibari village. This is reflective of the current national statistics regarding the use of contraceptives where the pill is the most widely used method and the use of injectables follows. In addition, women seem to prefer temporary methods (e.g., pill, injection, and condom) to the use of permanent methods (e.g., sterilization, IUD).

B. Conceptual Framework of Barriers

Our findings revealed many barriers regarding the use and preference of contraceptives in Bagnibari village. Our analysis of the factors influencing contraceptive use identified that the barriers were all intertwined within the three domains – individual, cultural, and socioeconomic, all having direct and indirect impacts on the use of contraception. The figure below visually explains the three dimensions and how they all relate to contraceptive use.

Figure 1: Conceptual Framework



To assist in the understanding of the above conceptual framework, some explanations of the direct and indirect relationships we found are as follows. Individual barriers, such as low levels of education, lead to lack of appropriate knowledge regarding contraceptives. The perceived and experienced side effects are only felt by the person, thus placed at the individual level. One cultural barrier is the preference of sons, which may discourage mothers (without a son) from using any contraceptive method and get pregnant again. The religion practiced by an individual will determine which contraceptive methods are considered prohibited, if any. The traditional Bangladesh culture, especially in the villages, assigns women to the typical role of being housewives. As a result, women have restricted mobility and therefore restricted access to the sources of contraception information outside of the realm of government provided family planning. However, some women have the opportunity to access contraceptive information through NGOs.

In terms of socioeconomic barriers, the weak services of government along with other factors like irregular visits and lack of proper counseling forced women to buy their contraceptives from pharmacies and sometimes these factors caused discontinuation and switched over. Though women have problem with some methods they have to continue with it because of cost effectiveness rather than appropriateness.

Of the various factors influencing the use of contraceptives, the most significant findings came from contraceptive side effects and the woman's age, occupation, and number of children. The women cited many perceived side effects influencing the contraceptive method of choice. Women reported having the following side effects from the pill: ten women reported dizziness; five complained of nausea, four of them talked about vomiting and three women reported weakness. Additional perceived side effects were: headaches, weight gain/loss, chest pain, and burning sensations in the head, chest, hands, and feet. Nine women reported that injections were causing menstruation problems (e.g., heavy bleeding, prolonged menstruations) either through experience or hearing from others. Although none of the women were users of the *Norplant* in the past or present, or knew anyone who had used it, they stated that *Norplant* had the worst side effects, including blurred vision, headache, heavy menstruation, and soreness. Reinforcing the idea that some women lack the appropriate contraceptive knowledge as stated by this woman, "Sometimes I willingly stop taking the medicine (pill). If I take for a long time

and stop for a month it will be okay. If I start menstruating I stop taking it for that month."

The women ranged in age from 21-45 years. Woman under the age of twenty-nine preferred using the pill compared to women above the age of 30 preferring injection. The women we talked to did not work outside the village. Fifteen women were housewives and only one worked within the community with a local NGO**.** Of the sixteen women, eight had more than two children and two women had four children. One woman with two children was satisfied, but stated that her husband desired more children.

C. Cultural Influences

From observation it was found that all the women came from Muslim families. Their religious beliefs influence their choice of contraceptive methods. The following statements further explain the Muslim influence as different women in the FGDs stated,

> *"We have to do everything according to our religion."*
> *"We follow religiously, but sometimes we have to use [methods] because we live in a society and have to keep our families small."*
> *"Some people don't use anything because God will punish them for not obeying the rules."*

Religious rules regarding family planning were primarily associated with the choice of avoiding sterilization, fearing that it would cause punishment from God after death.

The existing power dynamics between men and women in Bangladeshi society places women at a distinct disadvantage in the decision making process of contraceptive use. Ten of the women stated how they needed permission from their husbands to use contraceptives. The husband often chooses what method the couple will use but the woman is predominantly responsible with the burden of ensuring contraceptive use. Both men interviewed informally stated they did not want more children, but were not willing to use any methods so their wives must take the responsibility. One of the men stated that his wife had terrible side effects with contraceptives and wished his wife would get sterilized. His wife was against sterilization for religious beliefs and the man refused to get sterilized himself, therefore, the couple was now using condoms. Another woman stated her helplessness of having to use contraceptives that caused terrible side effects. Her husband refused to use any other method so she had to continue to use the pill because she could not go against her husband's decision. Data showed that men usually do not like to use condoms and refuse them often. In addition, women are the ones being educated by the FPWs on how to properly use condoms attributing to the continuation of the unequal power dynamics between men and women regarding contraceptive use. It was also quite evident that women experienced many challenges trying to balance their religious views and health while trying to practice family planning.

D. Socioeconomic Influences

The FPW stated that the majority of the couples of reproductive age are in the middle-income bracket. This statement was confirmed from our data findings. Only one woman had an average monthly income of less than BDT 6000 (a little less than 100 USD). The other women reported an income of between BDT 8000-12000 per month (between 100-150 USD). The pill is seen as the most cost-effective method to use because it can be used for a whole month, as a participant stated,

> *"We don't have enough money to buy enough condoms for a month.We can use pills for a long time."*

Therefore, people consider the condoms asan expensive contraceptive method because a package of condoms costs 10-25 taka and there are only three condoms per package. The pill lasts a whole month and protects against pregnancy during multiple intercourse. This is considered better compared to a condom which can only be used once. In reference to the other methods used in the village, the pill costs 35-60 taka per month and the injection costs 35-80 taka per injection.

All of the women were aware of the government family planning services that are available to them at the different levels (e.g., door-to-door, union health complex). Services provided by the government were perceived to be negative by the women at all levels of service. One woman complained that the health complex was too crowded and the waiting time was very long. All but one woman complained that because the contraceptive methods distributed from the government were free, the side effects were worse than contraceptives purchased elsewhere. The

women often did not accept the free contraceptives provided from the government and chose to purchase them elsewhere from local pharmacies and shops. In addition, the family planning worker stated the following common perceptions from women:

> *"They buy from the pharmacy. They think if it is free, it is not good (government contraception methods). They complain about more dizziness from the pill and stopped taking it from me. One lady stopped taking from me and I continued to visit her home. One day she told me she was having difficulty paying for the pill from the pharmacy and wants the free pill again."*

We found that, 12 of the 16 women using contraceptive methods purchase from the pharmacy and local shops. These shops are their primary sources for getting contraceptives. Only one woman actually used the contraception provided from the FPW and one other woman distributed the pills she had got from the FPW to others. The government provides an incentive for the IUD by providing 100 taka plus the cost of transportation. An incentive is also given for sterilization with a payment of 1,000 taka plus a *sari*(traditional long piece of clothing used by women) for a woman and a *loongi* (traditional long *skirt* for men) for a man. People are not motivated as the FPW informed us that only 1-2 women are sterilized each year. According to the FWV (Family Welfare Visitor), out of the union of eight villages, which Bagnibari is part of, only 2-3 women per month receive the IUD. In Bagnibari the FPW mentioned the use of the pill, injection, and condom as the predominant methods used.

IV. DISCUSSION & CONCLUSION

This study analyzed the influences of cultural and socio-economic factors in the use of contraceptives among rural women of reproductive age in Bagnibari village. Three domains were identified to explain the perceptions, preference, and barriers to contraceptive use – individual, cultural, and socio-economic. In addition, the three dimensions have direct and indirect relationships with the use of contraception. At the individual level, a woman's age, education, present children (e.g., number, age, sex), contraceptive knowledge and preference are directly related to the components of the cultural dimension (e.g., religion, power dynamics, lack of women's empowerment) and socio-economic dimension (e.g., income, occupation, contraceptive costs). This suggests the importance of women's involvement in the social-sector to further develop their status within society by increasing their opportunities for education and employment (Kabir et al. 2005).

The cultural aspect of women lacking independence by staying inside their home working as housewives isolates them from sources outside of Bagnibari village. It is important to note that some women do work outside of their homes, but we did not come across any during our study. As reported by Hanifi, "the low contraceptive prevalence has largely been attributed to the religious conservativeness of population" and the limited mobility that women have outside their home (2001). The women in Bagnibari village must depend on government services provided by the door-to-door FPWs regarding their knowledge and use of contraceptives. None of the women mentioned any activities provide by NGOs in their village or surrounding village focusing on family planning. Previous research found a similar finding that a woman's dependence on her husband has a significant role in the utilization of family planning services (The Schuler, 1999). Thus the idea regarding that the three domains are heavily intertwined and have a considerable influence on each another is further reinforced. This is an important finding because it supports the idea that family planning programs need to be addressed from a multi-level approach.

Women have limited socio-economic security due to the financial dependency on their husbands. This creates a correlation between the cost of contraceptives and the methods chosen. Further suggested by Kabir, "socioeconomic conditions exert both independent and joint efforts on family size. For instance, educational attainment of the woman is generally considered to be a useful index of socioeconomic status as well as the level of overall social sophistication and therefore it is inversely related to the desire for additional children and positively related to the use of contraception" (2005). Employment of women can assist to increase their independence and enable them to have a more active role in decision-making in all aspects of their lives, especially reproductive health. When women work outside of their home, they have increased access to additional information on contraceptive use to adopt an

appropriate method. Research suggests there is a positive correlation between employment and use of contraceptives (Kabir, 2005).

Although women have the availability to receive family planning services through FPWs provided by the government, it is not always an accessible source. Another study addressed that the, "low contraceptive prevalence has largely been attributed to…insufficient contact by field workers with clients" (Hanifi, 2001). Besides, women's views towards government family planning services are not positive. Women feel that because contraceptives are provided free of cost they are not good and cause more side effects. A gap of communication between FPWs and women is also a factor that influences the use of contraception. Many women could benefit from increased contact with FPWs. Increased visits would help the women in the village to build a relationship with FPWs and likely create an open forum for discussion regarding side effects instead of the usual distribution of contraceptives. In addition, women often do not know how to respond to side effects. Some women accept the side effects believing they are a natural process, while other women may try another contraceptive method or decide to forgo using contraceptive methods. A study by Schuler (1999) found women making similar contraceptive decisions when they experienced adverse side effects as stated here, "high rates of contraceptive discontinuation due to side effects are another sign that women are not receiving adequate information and counseling through the system of domiciliary services". It also created a lack of motivation to adopt permanent methods, pointing to their religious beliefs. As stated by Fahimi (2004), "sterilization as a family planning method is considered as interfering with God's will and attempting to change what God has created."

The peri-urban area of Bagnibari village is not significantly different from other areas in Bangladesh. "Bangladesh maintains a traditional social organization and is one of the least developed, predominantly rural, and poverty-stricken countries in the world. In addition, most of its people have a minimal level of education and women generally have a lower socioeconomic status than men" (Nosaka et al. 2008). Thus the relevance of our findings and the insight they offer can be applied to other areas of Bangladesh as well. Our methodology can also be applicable to future research addressing contraceptive use in other peri-urban villages.

V. LIMITATIONS

The sample size was too small even to gain a full emic perspective and the research period was very short. The study focused on the emic perspectives of married women, but informal discussions also included a few men to incorporate the male perspective of contraceptive use in Bagnibari village.But this may not be enough to gain insight into the men's views. Besides, all women were from the same religious group (Islam) and perceptions of contraceptive use may be different among members of other religions. Finally, access to accurate demographic data on the study population from a reliable and documented source was not possible.

VI. RECOMMENDATIONS

Advocating at a policy level to improve the service of family planning through empowering women and male involvement is necessary. This includes providing family planning counseling and education to both men and women individually and as a couple to create equal involvement in contraceptive use. The inclusion of a male family planning worker at field level will assist in improving CPR. This will have a positive impact on total fertility rate (TFR) over time and assist in women's empowerment so women can have a larger decision-making role in their reproductive health.

In addition, strong monitoring and evaluation services are essential to improve the performance of the government family planning program. The lack of counseling and motivation may be one of the causes of misconceptions, discontinuations and switching of methods. The current communication gap between FPW and women may be a noteworthy factor influencing contraceptive use which also created a lack of motivation to adopt contraceptive methods that are suitable for both partners.

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REFERENCES

1. Boonstra, H.(2001). Islam, Women and Family Planning: A Primer. *The Guttmacher Report on Public Policy*.4-6.
2. Central Intelligence Agency.(2010*). The World Fact book. South Asia :Bangladesh* .Retrieved at March 16, 2010, form https://www.cia.gov/library/publications/the-world-factbook/geos/bg.html

3]Demographic and Health Survey. (2007). *Bangladesh: DHS, 2004 - Final Report (English).* Retrieved at March 16, 2010, form http://www.measuredhs.com/pubs/pub_details.cfm?ID=526

4. Fahimi, F.R. (2009). Islam and family planning. *Population Reference Bureau.* Washington, DC.
5. Hanifi, S.M.A., & Bhuiya, A. (2001). Family-planning Services in a low-performing Rural Area of Bangladesh: Insight from Field Observations. *J HEALTH POPUL NUTR*, 19(3), 209-214
6. Kabir, A., Ibrahim, Q. I. U., & Kawsar, L. A. (2005). Relationship Between Factors Affecting Contraception and Fertility in Bangladesh. *Int'l Quarterly of Community Health Education*, 24(1), 45-53
7. Kamal, N. (2000). The influence of husbands on contraceptive use by Bangladeshi women.*HEALTH POLICY AND PLANNING*, 15(1), 43-51.
8. Mannan, H. R. (2002). Factors in contraceptive method choice in Bangladesh: goals, competence, evaluation and access. *Contraception*, 65(2002), 357-364
9. Nosaka, A., & Bairagi, R. (2008). Traditional Roles, Modern Behavior: Intergenerational Intervention and Contraception in Rural Bangladesh. *Human Organization*. 67(4), 407-416
10. Obermeyer, M. C. (1999). The Cultural Context of Reproductive Health: Implications for Monitoring the Cairo Agenda. *International Family Planning Perspectives.* 25(supplement), 50-51,55
11. Saha, U. R., & Bairagi, R. (2007). Inconsistencies in the Relationship Between Contraceptive Use and fertility in Bangladesh. *International Family Planning Perspective*, 33(1), 31-37
12. Schuler, S.R. (1999). The Next Chapter in Bangladesh's Demographic Success Story: Conflicting Readings. *Reproductive Health Matters*, 7(13), 145-152
13. UNICEF. (2010). *Bangladesh: Statistics.* Retrieved at March 15, 2010, fromhttp://www.unicef.org/infobycountry/bangladesh_bangladesh_statistics.htm