The other side of the story: providers' perspective on the barriers of using family planning of woman of reproductive age in Kampala, Uganda.

A qualitative study.

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Abstract

Background

Despite the wide spread knowledge and efficacy of family planning, use of family planning services remains low in Uganda. Therefore it is remarkable that no substantive research has been done to the perspectives of health care providers, with regard to the barriers for women to using family planning services. Thus, this study aims to examine the providers perspectives on the barriers to using family planning services for women of reproductive age in Kampala, Uganda.

Method

A qualitative study was carried out in Kampala, Uganda, among health providers who were active in and around the area of family planning in both private and public health centres. In-depth interviews were conducted with eight respondents with five health providers from private centres and three health providers from public centres. All health providers were active in the region of Kampala. Thematic analysis was used.

Results

The most important factors concerning the barriers of family planning use that emerged were divided into four themes: 1. The role of the husband, 2. Access to healthcare, 3. Access to knowledge, education and misconceptions about side effects, and 4. Culture and religion. Respondents argued that family planning currently is mostly a choice of women, hence they do not feel supported by their husbands. Besides that, public health centres were reported to often lack supplies and private health centres to frequently lack adequate knowledge about family planning methods. Furthermore lack of education, especially in rural areas, was reported to be the cause for the lack of adequate information resulting in many misconceptions about side effects. Cultural beliefs and religion were reported to still hinder people from going for family planning, though respondents also mentioned nowadays it is changing.

Conclusions

Lack of (adequate) information seems to be an overarching theme which leads to misconceptions about side effects and fear of using modern contraceptive methods. Health providers' recommendations were to increase awareness and provide adequate information about family planning methods and side effects. The provision of information should be adapted to different groups, in order to ensure that both men and women, in urban and rural areas, receive adequate information about family planning. This requires well trained and equipped health workers.

Introduction

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. People will accomplish their desire through the use of contraceptive methods or abortion.[1] For the past decades the promotion of family planning has been widespread in both western and third world countries.[2] This worldwide promotion is reflected in family planning being part of the Millennium Development Goals of 2015 (MDGs) covering six out of eight MDG's.[3] Family planning again being part of the MDGs that are set for 2020, implies that there is still a (high) need for international advocacy of family planning. [4]

The promotion of family planning in countries with high birth rates has the potential to avert 32% of all maternal deaths and nearly 10% of childhood deaths.[5] It would also contribute substantially to securing the well-being and autonomy of women,[6,7] the achievement of universal primary schooling, and long-term environmental sustainability.[1,2]

The need for family planning is especially high in areas with a high fertility rate. This particularly applies to the situation in Uganda where the persistent high fertility (6.7 children per woman) is contributing to the high maternal morbidity and mortality rates (435/100,000 live births) as well as the rapidly growing population (3.2%).[8-10] Despite this high need for family planning, the use of contraceptives by woman in Uganda stays remarkably low. According to the Uganda Demographic and Health Survey (UDHS 2011) only three out of ten married women report current use of contraception.[8] Furthermore, 48 percent of sexually active married women and 70 percent of sexually active unmarried women are not using any contraceptive method.[8,11]

Despite a liberal family planning policy in Uganda that allows access to contraceptive services to every sexually active individual and couples irrespective of age, there is a gap between the desire to restrict birth and actual contraceptive use.[12] Two out of five young women between 15 and 24 years old want to "space" or "limit" childbirth but are not using contraceptives.[13] This gap can be defined as the unmet need. This unmet need represents the percentage among woman in Uganda that are fertile, sexually active, but do not use contraceptives and yet do not have the wish to have children.[14] Approximately 34% of the women in Uganda have an unmet need for the use of contraceptive methods. By comparison, the unmet need in other sub-Saharan countries is 25%.[13,14]

Because of this high unmet need The Government of Uganda (GOU) has committed to reduce unmet need for family planning to 10 percent and increasing the modern contraceptive prevalence rate to 50 percent by 2020.[15] The GOU will attempt this by increasing its annual budget allocation for family planning supplies from US $3.3 million to US $5 million for the next five years, and to mobilize an additional US $5 million a year through donor financing.[15] This commitment is supported by multiple organizations like Reproductive Health Uganda (RHU), Community Empowerment For Sustainable Development (COMEDEV), Marie Stopes and Pathfinder.[16 – 19]

To achieve the goal of the GOU it is important to take into account the barriers that keep people from using family planning services. Various studies have been conducted to identify these barriers, a few of which are: 1) low perception of risk of pregnancy,[12] 2) health concerns about contraceptives and side effects,[11] 3) opposition to use (from husbands, families and communities),[20,21,22] 4) poor access to and quality of family planning supplies[20,22,23] and 5) services and inadequate information.[21,22] Because of the fact that health care providers play a central role in the delivery of family planning services and programme development, it can be of great value to take into account their perspectives regarding these barriers.[25,26] Mugisha and Reynolds (2008) conducted a study to the perspective of health providers on the quality of family planning.[21] In this study they highlighted that the providers' perspective should not be overlooked and they emphasized the importance of taking not only the societal but also the organisational factors into account. For example, at the organisational level, more effort should be put into the adequate training of health providers.[21] Pitorak et al (2014) showed that both women and health care providers considered financial constraints as one of the predominant barriers for using family planning.[27] A main outcome of the study of Nalwadda, who focused on young people in the rural districts, was that providers cited inconsistent, sporadic availability and poor method mix as limiting factors to methods of choice by clients in need of contraceptives.[27]

Despite these studies there are, however, gaps in existing literature on providers' perspectives.[21,] Thus, this study aims to examine the providers' perspectives on the barriers to using family planning services for women of reproductive age in Kampala, Uganda, and is intended to get an insight into the providers' perspectives on the future of family planning and their recommendations in order to increase its use. This knowledge can be used to optimize family planning programs and services in the country.

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Methods

Design

A qualitative exploratory study was conducted consisting of semi-structured in-depth interviews aiming at elucidating the perspectives of providers working in and around the area of family planning in Kampala, Uganda. This study took place in collaboration with 7Senses (Intercultural action research, -communication and –entrepreneurship) and a local community organization called COMEDEV-International (Community Empowerment for sustainable Development-International). These organizations together provided two Ugandan female researchers that cooperated during the research. The ethical committee of the International Mercy Ministry confirmed ethical approval to conduct this study.

Procedures and Participants

Recruitment of health providers took place in March and April in 2015 in Kampala by the help of 7Senses, COMEDEV-International and the two Ugandan researchers. Nine health providers were recruited using purposive sampling. The attempt was to obtain a diverse research population that is as representative as possible for the family planning health sector with respondents active at different levels in family planning in both private and public health centres.

Respondents were informed about the research and were asked for consent to participate in the interview. One respondent was not able to participate in the interview as his line manager did not give him permission. Eventually 8 respondents were interviewed of which 3 were working in a public health centre and 5 in a private health centre. (For further details see table 1).

Data collection

The interviews were conducted by a student (MCP) in Health Sciences from the VU University Amsterdam in the Netherlands who participated, prior to the interview, in multiple interview workshops organised by 7Senses, to improve the interview techniques. Preparation for the interviews took place in cooperation with two aforementioned Ugandan researchers to ensure research ethics, Ugandan (norms and) values and codes of conducts were taken into account.

To prepare for the interviews a topic list was constructed. Main topics were: opposition to use, religion, health care access and quality, the side effects and misconceptions about contraceptives, work field of the respondent, different family planning methods, role of the government, future perspective, and recommendations to increase the use of family planning services.

Conducting the interviews, the student was accompanied by a Ugandan researcher who acted as an interpreter. Respondents were assured that the interviews would be anonymous and that the purpose of the interview was to get to know the honest opinion of the respondent. During and after the interview the researcher made observation memos about the setting and the non-verbal communication of the respondent. After the first exploratory interview the interviewer got feedback from the Ugandan researcher with the aim to improve the interview techniques. After this first exploratory interview and during the rest of the data collection, some adjustments were made to the topic list. Among others, the topic of education was added and the focus of the interviews shifted from different family planning methods towards the actual barriers of using family planning.

All interviews took place in the health providers' work environment, varying from the waiting room to the doctor's office. The duration of the interviews was from 32 to 56 minutes and all were recorded and transcribed verbatim

Analysis

The transcripts were analysed using a thematic content analysis while data collection was ongoing.[28] The first step in this analysis was the familiarization with the data by reading it repeatedly and carefully. Following this initial step, the open coding of the first interview was started. In this first interview, data were explored and first codes were identified. Subsequently, the other interviews were encoded using these initial codes and new codes were added during the process of coding. Thereafter, codes were categorised and an attempt was made to form a thematic map including main themes that emerged. Using this thematic map, data of all the interviews were reviewed again to ensure all topics were included. A summary was made of each interview, including memos of the interviewer and additional quotes. These summaries were used to identify the differences and similarities between the interviews that were of help in writing up the results.

Results

In total eight in-depth interviews were conducted with five health providers from private health centres (one female midwife, one female nurse, and three male doctors) and three health providers from public health centres (one male doctor and two female nurses). All health providers were active in the region of Kampala. (Table 1)

Table 1: Characteristics of the 8 health workers included in the study.

Respondent	**Age**	**Sex**	**Health Centre**	**Profession**	**Work Experience (years)**	**Religion**	**Children**
1	34	Male	Public	Doctor	12	Catholic	-
2	24	Male	Private	Doctor	2	Catholic	-
3	38	Female	Private	Midwife	18	Catholic	3
4	29	Male	Private	Doctor	5	Catholic	-
5	20	Female	Private	Nurse	0,5	Catholic	-
6	33	Male	Private	Doctor	4	Protestant	1
7	32	Female	Public	Nurse	7	Catholic	-
8	42	Female	Public	Nurse	14	Catholic	2

Discussing the different barriers and facilitators of using family planning, several factors emerged. The most important factors were divided into four themes. These themes are: 1. The role of the husband, 2. Access to healthcare, 3. Access to knowledge, education, misconceptions about side effects, and 4. Culture and religion. Besides these barriers that were identified also the future concerning family planning in Uganda was discussed and thereby which changes could be made in order to increase the use of family planning in Uganda. Below is an outline of these different themes.

The role of the husband

Family planning currently in the eyes of most health providers seems to be a choice of women, whereas it should be a choice of both women and men. Respondents commented that family planning being a choice of woman comes from the idea that they feel unsupported by their husbands. Reasons that were given for this were amongst others that the men are busy working and therefore do not have time to join their wives to go for family planning.

R7: "They don't have time to come cause they have to work and look for money, you know if they accept at home, they talk about and sends the woman, you could give what she wants. But them they don't even, they don't bother, so much for family planning" [the husbands]

In addition to lack of time of the husband, two respondents also mentioned the husbands' fear of side effects of family planning methods.

R8: "There is also the men's fear for side effects. Because of this fear they will reject family planning."

According to the respondents this unsupportive role of the husband can result in the women coming for family planning without their husband knowing, which can cause some problems when the husband finds out. Thereby most respondents thought that when the woman comes for family planning without her husband, the information is withheld from him.

Access to healthcare

When discussing the access to healthcare the differences between public and private health centres emerged. The respondents from the public health centres seemed to have different opinions about the private ones and vice versa.

The public health centres are free and therefore many people go to them instead of private ones which results in long waiting lines. Two respondents from the public health centres said that they often lack medical supplies, which results in poor quality of care in that it reduces the range of choice that people have. Thereby it can also result in women getting pregnant when the right method is out of stock.

R7: "It is a problem because sometimes, some of them, they can come here when you don't have the method. It is over. They don't have money to go to the what, to go to the clinic to buy, so they end up conceiving"

Two respondents from private health centres and one from a public health centre argued that private health centres do not have long waiting lines and are more quick than the public ones. However, one public health care provider does not think this is always a good thing, she thought that you should take your time counselling someone. She also pointed out that private health providers do not get access to government refresher courses, and public health providers do. For these reasons she thinks that private health professionals can give incorrect and outdated information. But in comparison to the public health providers, the private health providers all say that they have enough medical supplies to offer the care they want.

Access to knowledge, education and misconceptions

All respondents reported that the level of knowledge in rural areas is much lower than in urban areas. Two respondents shared the opinion that the access to knowledge is a lot more difficult in rural areas, due to the lack of electronic equipment like radio and TV. Four respondents argued it is a lot harder to sensitize people in the villages because they tend to believe the rumours of neighbours and family more than the medical staff.

R6: "Totally different, urban they have some knowledge, but rural it's too much, too much poor, so health forces should be put, even when you put on radio and newspaper, rural people may not be able to access"

All respondents thought education and the level of education plays a role in using family planning. One respondent argued that uneducated people lack the information to understand family planning and its benefits, which can result in a negative attitude towards family planning.

R6: "I'm meaning, the uneducated may also actual be producing kids, and not controlling it because they are not aware on how to control him or herself"

Most respondents thought that educated people have a better understanding of family planning, its side effects and its benefits and are therefore more likely to use it. Also, one respondent mentioned that when the husband is educated he is more likely to come with his wife for family planning. In contrast, another respondent said that even the educated people can believe the rumours about misconceptions.

R8: "The high educated, they're the people that use family planning in urban area's eh. It is not the people using family planning in the villages, convincing those people and the men down there it is a bit difficult"

The lack of (health) education was suggested by the respondents to be the cause of people lacking information or having inadequate information. Next to lack of education one respondent also commented that the media is the cause, because the information they provide is not decent. Another respondent said that the cause are the health providers themselves. He argues that sometimes the health providers do not provide the adequate information because they simply don't have that information due to they have gone to missionary schools or did not get fresh up courses.

R2: "So they lack that information, otherwise if they had the information, then more of them would, really get it."

People lacking information or having inadequate information is argued by three respondents to be the cause of misconceptions about the side effects of family planning methods. Though one respondent thought that misconceptions about family planning methods and their side effects are reducing, most respondents think there are still many. They mentioned that people think that it can cause cancer and infertility or that you will get children with malformations. Four respondents thought that people mostly get this inadequate information from rumours from neighbours and relatives. These misconceptions are especially in the villages where people trust the rumours over the medical staff. These misconceptions could hinder people from going for family planning and keeps the use of family planning methods low.

R5: "You know with Africa we always have that, these beliefs eh, the beliefs they always have. So a lot of them go by them." […] "They think that when you're doing family planning method, you are going to bear children, who are you know, some of them born without hands."

R6: "Yes, misconceptions, though it is at now reducing, but still it is very big a lot. People have misconceptions I think, majorly they think family planning methods they are the cause of cancers, "

Culture and Religion

Five out of eight respondents think culture is a barrier for using family planning. Two respondents commented that there is still this cultural African belief that men want their women to produce many children because many children means pride, protection and security. Thus a lot of misconceptions come out of cultural beliefs. However, two other respondents thought that the influence of culture on family planning nowadays is changing and that cultural beliefs even seem to appear outdated. Though they commented that still in the villages they can play a big role.

R4: "Cause now as you see in Africa, we still have that belief that we have to produce as many as many children as possible. Cause now in Africa children are pride, he, the more children you have, people will be respecting you, so even that conception in their mind can hinder them from going for family planning methods."

Besides culture also religion was reported as a barrier. Some religions, such as Catholicism and Islam do not support family planning methods. One Catholic respondent even said that family planning, even it is preventing fertilization, is like killing human beings.

Religion does not only play a role in the decision whether people will use family planning, it also plays a role in the (Catholic) health providers' behaviour themselves. Two Catholic respondents reported that they struggle carrying on their job on the one hand, and being faithful to their belief on the other.

R4: But me as a Catholic, that's the way I consider it, you are murdering, why are you preventing it, cause that's god his nature, that's the way it's supposed to be, but again you are preventing,

I: But how do you feel then, being Catholic, providing family planning services?

R4: "Sometimes, it is a challenge, sometimes I find it is challenging, but eh, sometimes you just do, because that's the way how things are"

In contract, one protestant respondent commented that he did not experiences very big challenges with the church about family planning. Finally, one respondent said that she did not come across any patient in her clinic who came for family planning and struggled with their religion.
Religion not only plays a role in decision-making but also in health care access. One respondent explained that there are missionary schools that do not teach about the practical part of modern family planning methods and missionary hospitals that do not offer these family planning methods.

Future perspective

When talking about the future of Uganda concerning family planning, on the one hand two respondents talk about the consequences when the use of family planning stays low and said that this will result in the population growing rapidly, which causes problems with common services and resources.

R5: "The future of Uganda I would say it is in danger, because few people are into family planning, and eh most people, who are not into it, give birth to very many children."

On the other hand, two other respondents thought the attitude towards family planning nowadays is changing and the use of family planning is already increasing. One respondent thought that eventually the Ugandan people would start to appreciate family planning and understand its benefits.

Change

Discussing the changes that need to be done in order to eliminate the barriers, keywords mentioned by the respondents were 'sensitization' and 'health education'. Most respondents argued that this sensitization should be focused on both women and men, in order to ensure that also the men are involved. Three respondents said this sensitization is mostly needed in the villages, and should be done through the media and house to house visits.

Health education they thought should be given to different groups in general: the youth, men and health professionals. Just as sensitization, three respondents think the media should be involved in giving health education. One respondent said that the youth should be the main target and to reach them health education about family planning should be included in the secondary education programme.

R5: "Hm first thing may, what will be, maybe these man need a proper health education and sensitization about family planning. Cause the fact is both of us need it, the population is raising higher every other day, but we have nothing to do about it, because there is no way we can stop it when they are not aware of it, you need to really health educate them. "

Furthermore, three respondents commented that there should be a focus on targeting people in villages and rural areas. This could be done by the help of Village Health Teams (VHT's), but one respondent emphasized that it is important that these VHT's are accompanied by a health professional to make sure the information they provide is adequate.

R4: "My perspective is that Uganda since it is a lot developing country, you find that very, very, very many people deep in the villages, have not yet got the knowledge about family planning so as a country we need a lot of sensitization especially through the government, via the Ministry of Health, at least to get the people more information about family planning."

All respondents thought that this sensitization and health education should be done supported by the government. One respondent thinks the government is already playing a big role, but commented just like the other respondents that still many changes are needed to increase the use of family planning.

R2: "One is, health education. The Ministry of Health should try to go to the media and spread the information."

Discussion

Principal findings and implications

The findings of this study reveal the current barriers of using family planning and how they should be addressed according to the health providers. Main barriers identified were: the role of the husband, knowledge: access, education, misconceptions, culture and religion and access to healthcare. Below these barriers are described together with implications.

Education and the level of education was thought by the respondents to play a role in the use of family planning. This finding is consistent with other studies, as Andi et al (2014) suggest that the educational level is a predictor for the use of modern contraceptives.[29] The higher the level of education, the greater the odds that someone will use modern contraceptives. Teenage pregnancy also varies greatly with a woman's education. Sixteen percent of girls with secondary education have begun their reproductive life compared with 45 percent of those with no education.[11]

Lack of information seems to be an overall topic reflecting many barriers for using family planning. As respondents pointed out, this lack of information is the cause of many misconceptions about family planning methods and its side effects. Though this lack of information is consistent with most findings from other studies,[11,21] this contrasts with the study of Belezzi et al (2014).[30] They described that the lack of knowledge about contraceptives was rarely cited as a reason for non-use.[30] However they included the Demographic Health Survey of 35 countries so this could suggest that the barriers are different per country. Belezzi et al (2014) also reported that most women cited fear of side effects and health concerns, which could be put forward as a consequence of lacking adequate information about family planning methods.[30] A key finding from Kabagenyi was that men's lack of involvement together with fear for family planning methods and negative health beliefs stemmed from their overall lack of knowledge.[20] This lack of involvement and support was also commented on by the health providers in this study. The respondents thought this unsupportive role of the husband hinders women from going for family planning services. Besides lack of knowledge and fear of side effects they mentioned lack of time as a cause for the husband's unsupportive role. This unsupportive role can result in women coming for family planning without the husband knowing. This finding is in concordance with the results of the study of Mugisha (2008) in which they also reported many women secretly used contraceptive methods.[21] Besides that, they commented that informed choice loses much of its meaning when the primary use criterion of women is a family planning method that cannot be detected. The UDHS(2011) shows that only 56 percent of the women using contraceptives were aware of the possible side effects or problems that could occur.[11] Therefore it might be essential to focus sensitization about family planning on involving both men and women and to make sure people are well informed before starting any contraceptive method.

That there is a difference in the level of knowledge between rural and urban areas, was endorsed by all respondents. The reason given for this was that the access of knowledge was much lower in rural areas in comparison to urban areas. According to the UDHS (2011), women and men in urban areas are more likely to be exposed to family planning messages in the media than are their rural counterparts.[11] Regional variations showed that respondents in Karamoja, in rural northern east Uganda, are the least likely to be exposed to family planning messages from any sources, with 69 percent of women and 60 percent of men reporting having not seen or heard any family planning messages. By contrast, women in Kampala and men in Central Uganda have the lowest proportions of respondents (15 percent and 10 percent) who have not been exposed to any of the four media sources. In both rural and urban areas radio seems to be the most popular source for family planning messages.[11] A recommendation could be to focus more on providing information through radio, however, since this information is not recent (2011), it might not be representative of the current situation.

Culture and religion were found to be barriers that are more difficult to address. Though one respondent mentioned that she thinks cultural beliefs are changing now and are of less importance than before, they still have great influence in the rural areas. As is seen in the UDHS (2011) there is still a difference between the use of family planning in rural and in urban areas, 73,1 percent are not using any type of family planning method in comparison with 54,2 percent in urban areas.[11] Regarding these cultural differences between urban and rural areas, a suggestion could be to adapt family planning programs in Uganda to different groups. Besides, all respondents pointed out that some religions do not support or accept the use of modern family planning services which could deter women from using these contraceptives and cause a struggle for people choosing between their faith on the one hand and their desire to use family planning on the other.[28,30] This struggle is not only there for people who want to use family planning services, health providers themselves that have to carry out their job also sometimes find it difficult. The norms and values of a religion are extremely difficult to change. Especially when the pope, the head of the Roman Christian Church, is openly against the use of modern family planning methods. Despite this difficulty one respondent suggests that the church might function as a platform where information about family planning could be provided to increase awareness.

Surprisingly, none of the respondents mentioned financial constraints as a barrier for using family planning, since this turned out to be the predominant barrier in the study of Pitorak et al (2014).[27] This difference could be explained by the fact that their study only included providers from private health centres, which are not freely accessible.

Strengths and Limitations

Conducting this study, several strengths and limitations were identified. First, the Ugandan researcher that accompanied the interviewer was different for each interview. There were two Ugandan researchers present during the research. Which of the two attended the interview depended on their availability. Thus, the way in which the different interviews were conducted may have varied. However the interviewer herself was the same for each interview, thereby ensuring some consistency in the implementation of the research. Secondly, the interviewer had not previously conducted a qualitative study of this size, while abroad. Nevertheless, prior to the study the interviewer had participated in several workshops on interview techniques and intercultural communication. Third, transcription errors may have occurred in the interviews due to slight language barriers. Although the interviews were conducted in English, differences in accent, dialect, and poor audio quality sometimes made it difficult to decipher a small portion of the recordings. Fortunately these transcriptions errors could be restrained due to the presence of the Ugandan researcher during the interview. Finally, due to time constraints the study was limited by the number of respondents. Though both respondents from public and private health centres were included to obtain a perspective as truthfully as possible, the selection of health providers depended on the social networks of the Ugandan researchers which might have biased the research population.

Conclusions

Discussing the different barriers and facilitators of using family planning, several factors emerged. These were divided into four themes: 1. The role of the husband, 2. Access to healthcare, 3. Access to knowledge, education, misconceptions about side effects, and 4. Culture and religion. Lack of (adequate) information in the eyes of the health care providers seems to be an overarching theme which leads to misconceptions about side effects and fear of using modern contraceptive methods. This fear appears to cause an unsupportive role of the husband and hinders women from going for family planning. Recommendations given by the health providers to increase awareness were to sensitize and educate people about family planning methods and its side effects. This could be done by adapting the provision of information to different groups, in order to ensure that both men and women, in urban and rural areas, receive adequate information about family planning. This requires well trained and equipped health workers. Future research should look into different intervention methods suitable for different groups.

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