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REASONS FOR NON-USING FAMILY PLANNING METHOD IN ONE OF DEVELOPING COUNTRIES

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Abstract:-

The present paper is discussing the reason for non-using of family planning. In this study, a quantitative descriptive design with a positivist paradigm guided the whole research process. Two levels of sampling were done. The first was random sampling for the selection of healthcare centres where five healthcare centres were selected out of a total of eighteen. The second level was probability sampling with a systematic strategy, which was used to select the participants at healthcare centres. A total of 137 women volunteered to participate in the study and completed an anonymous questionnaire. The authorization to carry out the research was obtained from Nyagatare District and five healthcare centres. The research was approved by the University of KwaZulu-Natal Ethics Committee. The gathered data were analyzed using SPSS version 19.

Keywords: *Family planning, non-use of family planning, contraception*.

INTRODUCTION

Family planning is a service used to regulate the growth rate in low-, middle- and high-income countries. Many studies show that population growth is of concern for low-, middle- and high-income countries in terms of the high rate of infant mortality and maternal mortality (Thaxton, 2007; Jones, 2008; Casey et al., 2009). This impacts on the development of the countries and does not allow the achievement of socio-economic goals as well as the Millennium Development Goals by the year 2015 (Do, 2009). Family planning is one of the solutions that can be used to address population growth. In addition, family planning is a central feature of life and health for women all over the world (Griggs, 2009). In Rwanda, the Millennium Development Goals of 2010 showed that 27% of the people in the country are currently using contraceptives (Abbott and Rwirahira, 2010). There are two types of contraception: modern and natural. Modern contraception methods can be categorised in several ways. Hormonal methods include oral contraceptives, patches, vaginal rings, intramuscular contraceptives, implants and levonorgestrel intrauterine devices. Non-hormonal methods include male and female condoms and other barrier methods, as well as copper intrauterine devices. Implants and intrauterine devices, and sometimes intramuscular contraceptives are also categorised as long-acting, reversible contraceptive methods. Surgical sterilisation is a permanent method of family planning (Tsui, McDonald-Mosley and Burke, 2010) and abortion is classified with modern one. Natural method includes abstinence, withdrawal (fertility awareness, outercourse), and continuous breastfeeding (lactationalamenorrhea method) (Stacey, 2008). As a result of this, the researcher was interested to know the reasons for non-use of family planning at Nyagatare District.

Literature review

The following sections are literature review on reasons for non-use of family planning; methodology used to gather information regarding family planning, as well as results from respondents.

Reasons for non-use of family planning

The present paper is discussing the reason for non-use of family planning. At the beginning, we have quit look on literature. There are reasons described by literature for the non-use of contraceptive methods and will discussed accordingly.

Poor quality of available services

Childbirth and pregnancy is not a disease. It can however be the beginning of health risks whose effects could be minimised by utilising family planning methods as one of the healthcare interventions. Maternal deaths occurring during or after childbirth could be prevented or their complications or damage decreased if healthcare professionals act promptly to assist women through sufficient and correct equipment, skills and medicine. Murthy (2007) argues that the cost and physical inaccessibility of healthcare services could hinder childbearing in the presence of skilled health personnel. He refers to deaths occurring because of lack of resources and facilities even if there are qualified personnel available or present. Murthy (2007) adds that less educated and poor women also those living in rural areas are far less likely to give birth with the assistance of skilled health workers in comparison to better educated woman who live in urban areas or richer households.

Limited choice of method

Choice regarding contraceptive use and childbearing is among the vital decisions that people have to make. David (2008) states that communities need more information and simple explanations on decisionmaking regarding the benefits of family planning and the effects of different methods, to enable informed decision-making by these women. He adds that the benefits and importance of family planning can be explained beyond individuals, family and community, national and international levels. David (2008) speaks out that choices and decisions by families concerning family planning are most likely to meet individual needs where the decisions are based on relevant information, which is accurate and medically reasonable. It has been observed in many countries that family planning programmes are part of the national consideration for social and economic development efforts. Efforts to raise awareness about the reproductive right of society, community and family foster equity in decision-making and promote informed choices about family planning (David, 2008).

Fear or experience of side-effects

The side-effects experienced by users are of the reasons for quitting certain kinds of contraceptive methods. David (2008) argues that people choose contraceptive methods that are popularly used in their community because they know that it is communally acceptable to do so, and they also tend to know more about these methods. For instance, the Pill (progestinonly) may result in irregular bleeding, headaches, nausea, breast tenderness, etc. (Freeman and Shulman, 2010).

Cultural opposition

Cultural practices and beliefs combined tend to put girls and boys, women and men at risk of unwanted pregnancies and may stop people from practicing safe behaviours. Bisika (2008) reports that women in Malawi use the rope that is traditionally believed to protect a woman from becoming pregnant. In this community, there is a misconception about family planning. Women think that they will become permanently infertile if and when they make use of family planning

methods. However, the rope may not prevent pregnancy because the rope does not act as a barrier to spermatozoids or prevent ovulation.

Women carry the rope believing that they may not become pregnant even if they have unprotected sex. Intensive education about family planning in this community is required.

According to Judaism, procreation is a duty of males, but a commendable act for females; therefore, the husband must be informed in order to grant permission for the use of any sort of contraception method (Srikanthan and Reid 2008).

Religious opposition

Christian Connections for International Health (CCIH) is aware of issues concerning family planning methods and the way contraception is a concern among numerous members of faith-based groups. Several elements affect decision-making among Christianity believers. Huber, Martin, Wilson, Harris, Nesbitt and Fraser, (2010) state that the decisions about which methods are acceptable vary extensively among individuals and Christian denominations, and are influenced for some by whether the method is thought to act as an abortive means or to prevent conception.

Christian teachings differ depending on the denomination. According to the teachings of Roman Catholicism, the crucial purpose of sexual relations within marriage is procreation. Roman Catholics are consequently prohibited to use physical or medical contraceptive methods. Acceptable methods are natural contraceptive methods, i.e. abstinence (Srikanthan and Reid 2008). While Eastern Orthodox Christians hold a similar view of the purpose of sexual relations within marriage, the majority of contraceptive methods are allowed. Srikanthan and Reid (2008) add that liberal Protestants encourage procreation but also accept that marriage is for the purpose of sexual relations. The need to procreate reflects a literal interpretation of the Bible among conservative Protestant groups, yet it is common for adherents to use birth control after the family has desirable children. Among Protestants, no specific forms of contraceptive are banned (Srikanthan and Reid 2008). Hirsch (2008) reports that younger Protestant women in Mexico at least attempt to use withdrawal and periodic abstinence. Hirsch (2008) adds that the key reason for their preference for natural methods is their concern over the use of methods forbidden by the church. He further adds that all of the women in his study knew that the use of modern methods was regarded as sin by the church.

For centuries, Islamic scholars have been divided over the question of contraceptives. Many say the Qur'an prohibits birth control, while others argue that married couples can use contraceptives; however, it should not be used for reducing the overall number of children but only to increase the intervals between births (Melby, 2009). Melby speaks out that the Islamic faith does not believe in limiting the number children because children belong to God.

Gender-based opposition

Religious beliefs have a strong influence on gender roles in the relationships, influencing the decisionmaking in the relationship. In the Jewish society, for example, cultural rules as well as religion prescriptions apply. Procreation is a duty for males, but a commendable act for females. As a result, the husband must be informed in order to approve the use of any kind of contraception (Srikanthan and Reid 2008). In Iran, the husband is the main decision-maker regarding the number of children. One woman narrated what happened when she got married: "When I got married, my husband told me that withdrawal is better. However, I later realized that my husband's first choice was due to the fact that he sought to have power to control the childbearing time and the number" (Rahnama et al., 2010:289).

In the more patriarchal societies and in sub-Saharan Africa, men play a vital role in family planning. The decisions related to reproductive and sexual health are made by men, while reproductive and sexual health in its broader sense is the concern of both wife and husband. Consequently, many women are afraid to raise the issue of contraception for fear that their partners might respond violently (Kintu, 2010). Research by Orji, Ojofeitimi and Olanrewaju (2007) in Nigeria determined the role of men in family planning. This study showed that a high number of men agreed that decisions regarding family planning have to be made by both husband and wife. However, these decisions were found to be dependent on the age of the women.

Research by Donahoe (1996) in Bangladesh showed that young women had no influence in reproductive decisions while matured women (30years and above) tended to make their own decisions.

Methodology

In this study, a positivist paradigm (Weaver and Olson, 2006) was used with deductive logical reasoning. This paradigm makes the assumption that there is an objective truth existing in the world that can be explained and measured scientifically (Matveev, 2002). The data from the participants was objective truths that existed among them and which can be explained and measured scientifically. The researcher was separated from entities who were the subjects of observation.

The researcher used a quantitative approach (Burns and Grove, 2005; Moule and Goodman, 2009) that allowed him to count and measure events and perform a statistical analysis of the body of numerical data. This allowed the researcher to

generalise because the measurement was valid and reliable (Alasuutari, Bickman and Brannen, 2008). This approach was used because the data collected using the quantitative approach was clear and very precise and lacked ambiguity (Gilbert, 2008).

For this study, a descriptive (Keele, 2011) quantitative approach (Burns and Grove, 2005; Moule and Goodman, 2009) was used in order to understand the phenomenon under investigation. The descriptive study was chosen for this study for the simple reason that it afforded the researcher the opportunity to gain more information about the characteristics of the topic of interest (Keele, 2011).

Nyagatare District was the setting for this research. Nyagatare District is situated in the eastern province of Rwanda, bordered by Gicumbi District on the western side, Tanzania in the east, Uganda in the north and Gasabo on the southern border. Nyagatare District has 630 villages (*Imidugudu*), 106 cells and 14 sectors. The district occupies 1 741 km^2 of land and is inhabited by 291 452 people. The population density is 321 inhabitants per km^2. Nyagatare District has one hospital and 18 health centres (Nyagatare, Rukomo, Mimuli, Gatunda, Gakirage, Nyakigando, Cyondo, Muhambo, Nyagahita, Tabagwe, Ndama, Karangazi, Muhambo, Bugaragara, Kagitumba, Muriri, Rurenge and Kabuga) (DCDP, 2007).

The population of the study was women of productive age (18–49) living in Nyagatare District, Rwanda. The total population under study was 455 of those using family planning and antenatal clinics at five selected health centres (Rukomo, Rurenge, Bugaragara, Mimuli and Nyagatare). After selecting the health centres, the researcher contacted each health centre to obtain the overall number of people who come in for antenatal and family planning services. The total number found was to be 455, which made up the population size for the study.
The sample selection was performed by selecting the setting as well as selecting the participants in the study. For the selection of the setting, the research was conducted at five health centres functioning in Nyagatare District. These health centres represent 30% of all health centres in Nyagatare District, whichis an acceptable number for the generalisation of the findings. The selection of health centres in Nyagatare District was made by way of simple random sampling. The researcher obtained a list of all the health centres as the site of research, allocated numbers to each health centre and then put the numbers on separate slips of paper. The researcher deposited the slips of paper in a suitable container (bowl). Thereafter the researcher pencilled in a slip and made a note of its number, and replaced the piece of paper, shook the bowl and selected a second, and a third, and so on until five had been selected. This is called the fishbowl technique (Brink, 2006).In this technique, all health centres had an equal chance of being selected each time because the researcher replaced the previous slip selected. For selection of participants, a sample is a subgroup of the population of a researcher's interest (Kumar, 2005). At the health centres, the probability-sampling approach with systematic strategy (Brink, 2006; Kahl, 2011) was used. During the data collection period, the researcher chose women of reproductive age (18–49) who were present at health centres for family planning and antenatal services by selecting every third person. Interval (K) is calculated by dividing the population by the sample size. The sample of this study was 137participants from five health centres in Nyagatare District. The sample was obtained from 30% of the study population.To reach this sample size, participants were selected according to inclusion and exclusion criteria. The criteria that were used were the following:
Inclusion criteria:

All women attending family planning and antenatal services in the age group 18–49 years old were included in this research; women attending family planning and antenatal services, who were willing to participate in research; and; women attending family planning and antenatal services, who were willing to sign the informed consent.

Exclusion criteria Individuals with mental disabilities were excluded because of their vulnerability and inability to make decisions on their own; women younger than 18 years were excluded from the research because they were minors; women older than 49 years were excluded from this research because they were not of child-bearing age; women who were not living in Nyagatare District could not be part of the research; and woman who participated in the pilot study could not take part in the research.

Data collection
In this sub-section, the focus will be on data collection techniques and the data collection instrument. The researcher used a self-report questionnaire (Brink, 2006) to collect the data. This technique is used to explore participants' beliefs, knowledge and thoughts on contraceptive methods they use. The same author stated that this technique is the most effective method to obtain such information, namely to direct questions at the individuals concerned. It took approximately 20 minutes to complete the questionnaire.

This study used a self-report questionnaire. A questionnaire was designed by the researcher based on the tool used by USAID (Undie and RamaRao, 2010).

This tool was used for the contribution to global knowledge where the main aim was to prevent occurrence of pregnancy. The section modified is the section about family planning (Undie and RamaRao, 2010). The questionnaire was designed

in English and then translated into Kinyarwanda for participants who could not speak or understand English, thus allowing them to answer in their mother tongue. The translation was made by three Rwandan students, and then all translation were put together in order to agree on the proper, unambiguous words to use. After agreement, the final version was typed by researcher.

Validity and reliability

Validity is the way to illustrate whether the instrument is really measuring what it set out to measure or intended to measure as this shows whether the results are true. Validity is an indication of whether the research truly measures that which it intended to measure or how truthful the results are (Golafshani, 2003; Twycross and Shields, 2004; Gerhardt, 2004; Polit and Beck, 2008). Content validity is used to show the readers how the tool responds to the objective of the research interest. Twycross and Shields (2004) point out that content validity demonstrates whether the tool appears to others to be measuring what it says it does.

Reliability is dependability and consistency of a research tool used to measure a variable (Brink, 2006). There are many types such as internal consistency, stability and equivalence (Considine, Botti and Thomas, 2005). In this study, the instrument was tested and retested during the pilot study of ten women of productive age (18–49) who did not participate in the final data collection process of this study. The pilot study is an important stage for every new survey instrument. The pilot study is a small-scale preliminary study conducted before the main research with the intent to check feasibility of the instrument and to avoid waste of money and time as a result of inadequately designed research, as argued by Haralambos and Holborn (2000).

Data collection procedure

The researcher recruited one nurse at each health centre to assist with data collection. The researcher selected a qualified nurse who understood the questionnaire as intended by the researcher. Trained nurses helped participants who could not read to fill in the questionnaire. Participants dropped the completed questionnaires in boxes that the researcher made available during data collection. It took around 20 minutes to fill in the questionnaire.

The data was collected over a period of three weeks by the researcher and one nurse from each health centre assisted. The researcher then collected all the answered questionnaires from the health centres.

Data analysis

The data was analysed using the Statistical Package for Social Sciences (SPSS), version 19.0. To make data capturing and auditing easy, the data was coded. Descriptive statistics, such as frequencies and percentages, was used to synthesise the data. Basic statistics and frequencies were considered and are presented in tables or figures.

Ethical consideration

Ethical principles (Brink, 2006) have to be adhered to in all research done by students, staff or other persons. Cautious consideration to ethical issues were taken into consideration because we reside in a world with multifaceted interactions that have an impact on the health and wellbeing of the population of all nations regardless of individual or national prosperity (Harrowing, Mill, Spiers, Kulig and Kipp, 2010). The researcher made sure he protected the dignity and welfare of the participants in accordance with ethical principles. Ethical approval was obtained from the University of KwaZulu-Natal Ethics Committee. In addition, permission to conduct research was obtained from the General Director of Nyagatare District as well as the person incharge of each health centre. In this research the Ethical consideration was thoroughly considered in different angles: collaborative partnership, social value, Scientific validity, Fair selection of study population, Favourable risk–benefit ratio, Independent review, Informed consent, Respect for recruited participants & study communities and Data management (Ford, Mills, Zachariah and Upshur, 2009).

Results and discussion

The reason for not using family planning method varied to person to person. Table 1 shows the different reasons for not using family planning methods in Nyagatare District.

Table 1 Reasons for not using family planning

Variables	Yes or no	Frequency	Percentage
Religious prohibition	Yes	53	38.7
	No	84	61.3
Spouse hates it	Yes	50	36.5
	No	87	63.5
Need for male child	Yes	65	47.4
	No	72	52.6
Need for female child	Yes	53	38.7
	No	84	61.3
Fear of side-effects	Yes	54	39.4
	No	83	60.6
Reduce coital satisfaction	Yes	48	35.0
	No	89	65.0
I am afraid to kill my children	Yes	26	19.0
	No	111	81.0
Not aware of the method to be used	Yes	66	48.2
	No	71	51.8

In Nigeria, the main reasons for not using family planning are fear of side-effects and the husband's disapproval (Olugbanga-Bello, Abodunrin and Adeomi, 2011). In Nyagatare District, the reasons for not using family planning were that some people are not aware of family planning methods (48.2%), the desire for a male child (47.4%), fear of side-effects (39.4%), prohibition by religion (38.7%), the desire for a female child (38.7%), husband dislikes it (36.5%), belief that it reduces coital satisfaction (35.0%) and fear of killing children (19.0%). Of the participants, 9.5% suffered from side-effects. The study did not establish the kind of side-effects from which participants suffered but only aimed to find the factors influencing family planning. The fear of side-effects could be the reason why there are few clients using family planning services.

A male child is more desirable than a female child in Nyagatare District as shown by the reasons for not using family planning as 47.4% and 38.7% respectively. In Sudan, the main reasons for not using family planning were that people want many children and fear of side-effects (Ali et al., 2011).However, in Nyagatare, the main reason was that the people were not aware of family planning methods. Education is required in order to enhance the level of understanding regarding family planning methods.