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Barriers to use contraceptive methods among rural young married couples in Maharashtra, India: Qualitative findings

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Abstract

Introduction—In rural India contraceptive use remains uncommon among newly married couples. non-use in rural young couples contributes to higher fertility rates.

Objectives—To identify barriers of spacing contraceptive use among young married couples in rural Maharashtra.

Methods—In-depth interviews were conducted with husbands (N=30), wives (N=20), and village health providers (N=12); additionally, 3 focus groups were conducted with mothers of husbands (N= 42 focused on understanding contraceptive use and barriers. Interviews and focus groups ranged in length from 90–120 minutes. Detailed notes taken during interviews were analysed using a grounded theory approach and the data was analysed using atlas-ti software.

Results—Major barriers to spacing contraception are: pro-natal social norms, pregnancy expectations early in marriage, to produce multiple sons, limited access to modern spacing contraceptives, family resistance to adopt contraceptives, lack of husband's involvement on family planning issues, myths, misconceptions, perceived side effects and negative attitudes toward specific contraceptives.

Conclusion—Findings highlight the intersection of norms against spacing contraception, traditional gender ideologies and lack of male involvement as major barriers to the use of contraception. Male oriented outreach programmes on family planning. Promoting gender equity should be made through health programme deliveries with special focus in rural areas.

Keywords

Contraception; gender equity; male involvement; tribal-non tribal; marital communication about family planning

1.0 Introduction

Rural India continues to be characterized by high andearly fertility, due to the commonality of adolescent marriage and non-contraceptive use prior to female sterilization, a procedure typically occurring after age 30 years (NFHS-3, 2007). In fact, family planning programs often attempt to reach these young wives only after they reach their family size goal, despite indications that newly married young couples would prefer to delay first birth. Among rural wives aged 15–24 years, contraceptive use is reported by only 18% of the population and the majority of these women opt for female sterilization rather than spacing contraception, even at this very young age (NFHS-3, 2007). More than 60% of young women in rural India are married prior to the legal age of 18 years, and adolescent and young adult wives (age 15–24 years) are more likely than older wives not to use contraception and have unplanned and rapid repeat pregnancies. Consequently, 37% of married Indian women 15–49 years have been sterilized, and 77% of sterilized women report never having used any other contraception prior to their sterilization (NFHS-3, 2007). Improvements in spacing contraception use are a goal in India, but clearly have had limited success (Liberhan T, et al, 2013). This study examines qualitatively reasons for non-use of spacing contraceptive methods among young rural couples, their health providers, and mothers of young husbands in rural Maharashtra, to guide spacing contraception programs. Prior research documents both practical and sociocultural barriers impeding use of spacing contraception, but much of this work is more than a decade old. Practical barriers historically included cost, in both time and money (Nag, M, 1984; Janowitz, B. and J.H.Bratt, 1996; Lewis, M.A, 1986). Over the decades, however, there has been considerable expansion and strengthening of the public health care infrastructure and family welfare services across the country, and only a negligible minority of women (<5%) perceive availability, accessibility or cost as major impediments to using contraception (NFHS-3, 2007; IIPS and ORC Macro, 2001). Nonetheless, in practice, access to and availability of quality services are significant issues of concern. Where workers are available, they are generally poorly trained and have little knowledge of the methods they are to provide. Older providers, trained under the historic public health approach emphasizing female sterilization, may also be less supportive of provision of spacing contraception (Bertrand, J.T., et.al, 1995; Baveja,R., et.al., 2000; Donaldson, P.J.,2002) Limited knowledge regarding family planning methods and particularly spacing contraception was also an historic concern (Baveja,R., et.al., 2000; Basu, A.M., 1984; Chaudhury, R.H., 2001). Currently, however, the small family norm is widely accepted (the mean ideal family size reported by young people currently is 2.5 children) and general awareness of contraception is universal (99% of currently married women in the reproductive age group were aware of a contraceptive method) (NFHS-3, 2007). However, awareness of modern spacing contraception is least likely among rural young wives, particularly married adolescents and those early in marriage (NFHS-3, 2007; Santhya, K.G., 2004). Even among those aware of modern spacing contraception, historic research documents myths and misconceptions regarding its side effects and potential health consequences (Chaudhury, R.H., 2001; Bongaarts, J.and J. Bruce, 1995; Rani, M. and S. Bonu, 2003; Char, A., 2001; Rajaretnam, T. and R.V.Deshpande, 1994; Athavale, A.V. and S.A. Athavale, 2003) as well as fears regarding in effectiveness of these methods (Chaudhury, R.H., 2001; Bongaarts, J.and J. Bruce, 1995; Char, A., 2001; Athavale, A.V.

and S.A. Athavale, 2003). Little recent research from India provides insight into whether these concerns remain. Socio-cultural concerns related to prescribed social roles of motherhood as well as expectations regarding childbirth, son preference, and family size (Saavala, M., 1999; Blanc, A.K., 2001; Chacko, E. 2001) are major issues preventing spacing contraception use, and continue to disproportionately affect rural women (NFHS-3, 2007). Women's limited autonomy in these contexts combined with social expectations regarding her becoming a mother and having son results in lack of acquisition of reproductive health services (Stephenson, R. and A.O. Tsui, 2002). Social stigma against contraception use, particularly in early marriage, historically reinforced non-use as well (Nag, M., 1984; Bongaarts, J.and J. Bruce, 1995) Research has also documented that individual beliefs of women, husbands and families, particularly mothers-in-law, in India are often more tradition in the rural context, resulting in more restrictions and religious prohibitions related to sex, contraception, and expressions of reproductive health care needs (Nag, M., 1984; Rajaretnam, T. and R.V.Deshpande, 1994; Saavala, M., 1999). How these issues and concerns may be shifting is not well understood.

Based on the review of the literature on barriers to modern spacing contraceptive use, it is clear that low utilization remains a concern but research on this issue has not been a focus in the past decade. The current study offers a qualitative analysis of barriers to modern spacing contraception from rural husbands and wives, but also from influencers of the behaviour in the health care system, specifically public and private health providers, and within the household, specifically mothers of husbands. These findings may offer important insight to improve public and private health reach of spacing contraception to rural young couples in India.

2.0 Methods

Qualitative data in the form of in-depth interviews and focus groups were collected from rural young husbands, wives, health providers and mothers of young husbands in March 2011, to understand barriers to spacing contraception use for young couples in rural India. Data were collected as part of the formative research phase of the Counseling Husbands to Achieve Reproductive Health and Marital Equity (CHARM) intervention study – a male-centered family planning program, and used to inform CHARM intervention development. Data were collected from participants in two non-adjacent villages in Thane, Maharashtra, which were identified via community mapping. Villages had populations>1000 residents and no rural public health centers within. Thane, like much of rural India, is characterized by high rates of adolescent marriage and childbirth, low family planning use, and higher maternal and infant morbidity and mortality.

2.1 In-Depth Interview Recruitment and Procedure

In-depth interview data were collected by trained bilingual research staff who held Masters degrees in either psychology or social work; staff were sex-matched for interviews with husbands and wives. Research staff were trained on issues of family planning, gender equity, and interviewing. Husbands (n=30) and wives (n=20) were randomly selected from preexisting lists of eligible couples available from public health centers serving each of the 2

designated study villages. Eligible criteria included young married couples who were aged 18–30 years, currently married and residing with their spouse for the past 3 months, and reporting no sterilization for either spouse. Husbands and wives were not recruited from the same households. Research staff screened 43 women, of which 37 were eligible and 20 agreed to participate in the study (54% participation rate). Fifty men were screened, and of these 42 were eligible and 30 agreed to participate (71% participation rate). Health provider participants (n=12) were invited from the full listing (collected by research team) of 25 private and public health providers serving the villages of focus (48% participation rate). Health provider participants included 8 private health providers (doctors of allopathic or AYUSH [traditional] medicine), and 4 public health providers (doctors of allopathic or AYUSH medicine, Auxiliary Nurse Midwives).

For all interview participants, research staff described study objectives and procedures at recruitment, and assessed individuals' eligibility and willingness to participate. If interest was indicated, participants provided written informed consent immediately prior to the interview. All in-depth interviews took 45–60 minutes and were conducted in Marathi. Male and female in-depth interviews focused on gender attitudes and norms (e.g., male decision-making control, son preference) around family planning and reproductive health service utilization, norms of spacing methods of contraceptive use, contraceptive and fertility practices within marriage, and marital family planning communication. Research staff interviewed participants using a structured interview guide. Service provider interviews focused on knowledge and perceptions about spacing contraception, perceptions regarding barriers and facilitators to rural young couples' family planning behaviors. After the interview, participants were thanked for their time, and husband and wife participants were given information about public health family planning programs. During interviews, notes were taken by the interviewer in Marathi for data, as audiotaping in-depth interviews is not well received in this context. Within 2 hours of the interview, the staff member added details to the notes and typed them into word files; these notes were then translated by the staff member into English.

2.2 Focus Group Recruitment and Procedure

For focus group participants, key stakeholders from the village (e.g., village leaders, health providers participating in the in-depth interview study) recommended households were mothers of rural young husbands could be recruited, and those recommending mothers-in-law helped research staff recruit them into the study. Of 67 mothers invited to participate, 40 agreed (60% participation rate). Focus groups were conducted by trained bilingual female research staff who held Masters degrees in either psychology or social work. Research staff interviewed participants using a structured interview guide. Focus group discussions were used rather than in-depth interviews for this population to obtain information on norms rather than personal experiences of these mothers. All focus groups were conducted in Marathi at a local Anganwadi Center (social service center) in each study village (2 groups in the larger village, 1 group in the smaller village). Informed consent was obtained from participants immediately prior to the focus groups. Focus groups were two hours in length and assessed perceptions regarding role of the daughters-in-law in the family, son preference and family planning, spacing contraception and the role of mothers-in-law on family

planning decisions. In-depth notes were taken by another female staff member during the focus group, and transcribed and translated into English within 24 hours of each focus group. FGDs were recorded, however due to noise interference and equipment malfunction, audio recordings were not audible.

2.3 Human Ethics Approval

No monetary incentives were provided to participate. All study procedures were reviewed and approved by the Institutional Review Boards of the National Institute for Research in Reproductive Health, Boston University and the University of California at San Diego.

2.4 Data Analysis

Upon completion of full data collection, the investigator team reviewed all data. Codes were then developed inductively and iteratively, subsequent to actual coding of data. All codes were designed to be mutually exclusive, but possibly linked. All data were independently coded by two Masters level trained coders using Atlas.ti v5.0, a computer-based textsearch program that allows multiple codes to be searched and linked simultaneously. When new codes were identified by coders, they met to agree upon the new codes, introduced them to the investigator team with example coded data, and if all agreed, added the new codes to the list. They would then go back to previously coded data to ensure newly identified codes were coded across all interviews and focus groups. If coders did not agree, a senior level investigator made final decisions on coded material; this senior investigator also periodically reviewed coding in process to monitor data analysis for quality control purposes. Codes generated through this process focused on barriers to spacing contraception use for rural young couples. These included pro-natal norms, son preference, family prohibitions against contraception use, inhibition of male involvement in family planning, lack of contraceptive knowledge, beliefs regarding contraceptive side effects, negative attitudes toward condoms, and preference for natural methods or sterilization over modern spacing contraception.

3.0 Results

3.1 Pro-Natal Norms

Husbands and mothers of husbands described family expectations that couples should have children soon aftermarriage, ideally within a year of marriage to demonstrate health and fertility and marital happiness. Women are held responsible if a child is not born early in the marriage and can be mistreated for it. Such beliefs can affect contraceptive use in early marriage and prior to the birth of the first child.

> “There is pressure from elders in the family. If we don’t have child soon after marriage, then they will speak badly about the wife. They will consider it as her fault and taunt her. The[y] will think that she is infertile.” (Husband 24, Age 23)

> “Many times if the couple doesn’t have child after the marriage of one year, then others feel that there must be a problem between the husband and wife.” (FGD 2 Mother-In-Law 4, Age 60)

> "If the couple doesn't have children after 4–5 years of marriage then we also feel that they should have children. We tell them to go to the doctors or find out whether there is any effect of devil. There is superstition among people." (FGD 3 Mother-In-Law 6, Age 40)

3.2 Son Preference

Sons are preferred over daughters by both husbands and wives. Family size and decisions about use of contraception often depend upon the sex of first child, with contraception being less likely if a boy has not been born. Non-use of contraceptive methods may occur until the desired number of sons is achieved.

> "The number of children is decided after the birth of the first child. It only depends upon whether the first child is a son or a daughter." (Husband 17, Age 29)

> "I didn't get a male child. We will wait for a male child… Our family (parents) will not agree to have only girl children. We have to obey their command. We can't take (our own) decision on this." (Wife 01, Age 21)

Son preference is rooted in cultural traditions where boys and not girls are the heirs of the family name, property/wealth, and family voice in the community. Males are also responsible for parents as they age. Girls are expected to leave the family at marriage, and are thus viewed as having no significant contribution to the family.

> "Everybody gives preference to male child only… We will be grandparents of our sons only. The inheritor of our property should be the male child. Our surname will be held by our male child only. For all these reasons there is a family pressure, and all these factors influence demand for a male child." (Husband 07, Age 30)

> "If there are already 2 to 3 girl children in the family, still, the birth of the son child is eagerly awaited. There should be a male in the family "Aaplya vaunshala diva asawa". Who would take care of us in the old days? Who would be the inheritor of our property? Such types of some traditions are seen." (Health Provider 12, Male, Age 36)

> "Son preference is a common thing in this village; a son is a must for the funeral (Chita) rituals after our death." (Husband 05, Age 23)

Even if the boy comes with concerns, the view was that it was better to have a male rather than female child, because girls may not be permitted to support their parents after marriage. In contrast, even if the girl is reliable, she is viewed as a burden due to dowry and the view that she belongs to someone else's household after marriage.

> "Even if a son is an alcoholic, he still takes care of his parents because he stays in the same home, and it is his responsibility. A daughter goes to someone else's home, and even if she wants to come and see us, she has other responsibilities and cannot always be there for us. The son will always take care of us in any situation because he doesn't have to ask someone else before he can care for us. Daughters have to ask her in-law's permission if she has to come to see us." (FGD 3 Mother-In-Law 6, Age 40)

If a woman does not bear sons, she may be subjected to threats of abandonment by her husband. Such threats may come from both the husband and his family.

> "Women have pressure from family and husband. They are scared that if they will not give birth to boy child, then her husband will leave her. So she keeps on giving birth to children." (Wife 06, Age 24)

> "Son preference is more in this community. Couples are not using any spacing method nor do they do sterilization until they…get a male child. If there are three girls or four girls, still they will not use any spacing method. If the woman can't produce the male child, then in-laws or her husband harass her for a male child. They threaten her that he will go for second marriage. In such cases, a woman may bear a number of pregnancies until she gets a male child." (Health Provider 01, Age 47)

Mothers-in-law may also mistreat their daughter-in-laws if they do not bear sons.

> "My mother always expresses her anger by taunting my wife, because we don't have a male child." (Husband 01, Age 23)

Sex-selected abortion was noted as an option to women for fertility control in the face of husband and in-law pressures to continue to bear children for a son.

> "Initially couples don't only want a son; they want a daughter also. …Couples want another son! They don't want a daughter. When the women are pregnant, couples go for sex diagnosis, and if there is daughter, they go for abortion." (Wife 19, Age 21)

Family prohibitions against contraception use- Husbands and extended family may actively prohibit female contraception in their effort to ensure the birth of sons.

> "Due to patriarchy, women cannot make the decision about their family planning… She has to bear a number of pregnancies if she doesn't get a male child. Though she may want to have surgical sterilization after two deliveries, she doesn't have the right to do so according to her family. We try to convince her family to have a small family. Usually due to son preference, the couple doesn't use any family planning method." (Health Provider 02, male, Age 27)

Men may also prevent family planning for other reasons, such as use of alcohol and, subsequently, unwillingness to use condoms. The men are able to do so because they often have greater dominance in the marital relationship.

> "There is alcohol consumption among men, and when they are drunk they become dominant. Men are taking decisions about the family, and they are not ready to accept such contraceptive methods." (Wife 10, Age 24)

3.3 Involvement of men in family planning

While men may prohibit family planning or force childbearing, they are simultaneously not expected to take responsibility for family planning, if that is the preference for the couple.

> "Male are the dominant in the family. (But) They are not ready to choose any family planning method… Most of the men think that it is not their responsibility." (Health Provider 01, Male, Age 47)

If a husband is involved in family planning decision-making or supporting his wife on these issues, he may be ridiculed by peers or villagers.

> "If men get involved in family planning, people will say that he cares for his wife a lot. He only listens to her. They will say that he is henpecked husband. He doesn't use his brain. He always does as his wife says; he himself doesn't know anything. His parents will tell him, 'You don't listen to us; you don't care about us. Since she has come you give more importance to her than us. People will say that you neglect us." (Husband 10, Age 29)

Spousal communication on these issues and joint participation in family planning education is thus compromised.

> "Even today in our society, husband-wife discussions about the sexual life are not considered to be appropriate. And the couples are also not interested in such discussions since they feel shy to talk with others. So they do not feel that it is the need to seek family planning education services." (Health Provider 12, male, Age 36)

Lack of knowledge regarding contraception remains, despite service availability. Health providers reported that many couples lack family planning knowledge and acquiring that knowledge is not a priority to them in this context of poverty and labor.

> "People do not try to understand about family planning methods because here the people are very poor. They are busy in their daily work. When information on family planning methods is given, people are not there to listen." (Health Provider 01,Male, Age 40)

> "Rural and tribal people are not interested to know more about use of spacing contraception or other family planning methods." (Health Provider 08, female, Age 52)

Under the National Rural Health Mission, outreach to women in villages to promote family planning has been undertaken. However, even in this context, some women are not fully acquiring family planning education; feel shy to discuss sexual issues or inadequate family planning methods with the health care provider.

> "Women are coming but they are not openly talking about that type of subject because they are very shy. Some of the women are illiterate, and because of it they do not remember their menstruation cycle days. This creates a problem for them to take their orals pills regularly. They are likely to forget. They come after a missed period, and they do not want a child. Some women meet the Auxiliary Nurse Midwives (ANM) and get the information, but have misunderstanding about the use of the family planning method." (Health Provider 07, male, Age 50)

3.4 Fear of side effects from oral contraceptive pills (OCP)

Husbands and wives highlighted several physiological side effects of the OCP, based on both perceptions more often than experience. Women described nausea and abdominal pain.

> "Oral pills are powerful tablets which emerge heat in the body… Sometimes oral pills don't suit your body. It can get sensation of watering in mouth, vomiting or stomach ache can happen." (Wife 02, Age 24)

Men described even more severe health effects, and this may be due to their lesser access and acquisition of contraceptive knowledge. The perspectives also appeared to come more from hearsay rather than from their wives' experiences with the OCP.

> "Pill has adverse effects on health. It prevents pregnancy. It is not good for women." (Husband 11, Age 25)

Husbands and wives expressed concerns that OCP use long term would lead to irregular menstrual cycles and ultimately result in women's infertility.

> "People say that pills are not good. If we consume pills in more quantity, then we will not become pregnant ever. Some of them don't have child for two to three years and they feel that because they were using pills they are not getting pregnant. Also it leads to irregular menstrual cycle." (Wife 14, Age 21)

Some husbands also noted weight gain as a problematic side effect to OCP.

> "My wife fears for getting fat, so we discontinued the oral pills". (Husband 01, Age 23)

Even some health providers expressed concerns regarding side effects of the OCP.

> "Oral pills cause cervical cancer to women who consume these pills for many years… Adverse effects are also in the pills if women forget to take pills as per prescribed by the health provider." (Health Provider 05, male, Age 32)

3.5 Fear of side effects from intrauterine devices (IUD)

Husbands and wives also highlighted several physiological side effects of the IUD, specifically the Copper T, again based more on perceptions than experience. Women described abdominal pain and fatigue.

> "Because of the Copper T you may get headaches, pain in the stomach, stomach pain and heavy bleeding at menstruation, and excessive tiredness. You get weakness, and you start losing weight." (Wife 18, Age 26)

> "Sometimes Copper T suits on your body or sometimes it doesn't suit. Women become thin (Kadki Basate), She physically becomes weak (Tabyet Utarte, Kadki Hote)." (Wife 11, Age 24)

As seen with beliefs regarding the pill, husband concerns related to IUD were even greater than those of wives.

> "Some people say that the Copper T goes to the heart." (Husband 02, Age 30)

Due to such negative perceptions regarding the Copper T, providers discourage women from letting others know when they have had one inserted.

> "If a woman inserts a Copper-T, we have to keep secrecy. We tell them not to tell about it to anyone as there are lots of misconceptions about Copper-T, and others may tell them stories which may lead that woman to remove the Copper-T."(Health Provider 06, female, Age 49)

3.6 Negative attitudes toward condoms

Husbands reported that condom use was for outside of marriage and in extramarital affairs, for both pregnancy and HIV prevention.

> "If you have any affair outside of marriage, then you should use nirodh (condom). If you don't use them, then conception may happen. Then you have to marry with them. Your reputation will be affected. This is what people say." (Husband 15, Age 25)

> "In this village mostly men talk about condoms with friends regarding HIV only. They don't think about condom as a family planning method." (Husband 20, Age 20)

Husbands also described how condoms inhibited sexual pleasure, and that prevented them from continuing use of condoms.

> "I have used nirodh (condom) once or twice, but after that didn't use it because it doesn't give enjoyment." (Husband 13, Age 23)

> "Because of using nirodh we don't get enjoyment, oily part of it doesn't feel proper. That's why I used once or twice and stopped." (Husband 13, Age 23)

Sometimes husbands stopped condom use at the wife's request, and for her enjoyment.

> "After using nirodh (condom), my wife told that she is not feeling comfortable and not enjoying. Because of this complaint of wife, we stopped using nirodh." (Husband 14, Age 26)

Husbands reported concerns related to the reliability of condom use. Worries of condom breakage were particularly strong.

> "The disadvantage of condom is that it can break. Therefore, there is fear of getting pregnancy." (Husband 11, Age 25)

> "If nirodh (condom) is not of good quality, then it can get torn." (Husband 13, Age 28)

Disposal of the condom subsequent to sex was also viewed as an issue by some husbands, as there are not garbage cans orwaste disposal in this context.

> "I have not ever used a condom, because I do not know how to dispose it? Children may use it for playing. When I think about that, I get restless. Therefore, I never used it." (Husband 07, Age 30)

Wives provided almost no comment on condom use. One wife who did demonstrated fear and lack of experience with this method.

> "I get scared that if we use condom it will pain." (Wife 14, Age 21)

3.7 Reliance on natural methods rather than spacing contraception

Husbands in particular seemed to prefer natural methods to avoid pregnancy. This approach was viewed as healthier and simpler, and thus better. However, it was unclear whether there was full understanding how to effectively use natural methods to prevent pregnancy.

> "We don't use any family planning method. I don't like it and don't have information much about it, because I don't like touse it. I like to live simply… We can live properly by controlling our self." (Husband 25, Age 30)

> "I have never used any family planning method. We don't keep physical relations at the time of menstruation for 10–15 days. For the rest (we have sex) without using anything. We keep control on ourselves so we are able to keep this spacing." (Husband 25, Age 30)

> "We reached on the decision that we will use only rhythm method. My husband told me that I am very weak, delicate (Najuk). (He worries) whether any method is suitable to me or some side effect will occur. From the start of marriage, we are not using any contraceptive." (Wife 12, Age 21)

The natural method is also viewed as more economical.

> "I haven't used any method until now because why to spend money on it? If there is mistake in using a contraceptive, then it doesn't benefit you. Hence, I am not using anything." (Husband 23, Age 28)

3.8 Reliance on sterilization

Female sterilization is often the preferred means of contraception, subsequent to achieving the desired number and sex of children.

> "In our pada (village area) couples mostly give preference to female sterilisation (for contraception). When they feel that their family is completed, then women take initiative to get the sterilisation." (Wife 03, Age 22)

Tribal communities in particular report strong preference for sterilization.

> "Tribal are not open for using spacing contraceptive method. They only get ready to do sterilization. Non-tribal may do it." (Health Provider 06, female, Age 49)

4.0 Discussion

Findings from this qualitative study of barriers to spacing contraceptive use in rural India demonstrate that sociocultural concerns related to expectations of pregnancy early in marriage (pro-natal norms), importance of having boys (son preference), and lesser control for women relative to men or even in-laws in reproductive decision making (low female reproductive control) remain key barriers to non-use of spacing contraception. Such

findings, similar to those seen in prior research (Liberhan T, et al, 2013; Santhya, K.G., 2004; Athavale, A.V. and S.A..Athavale, 2003; Saavala, M., 1999; Blanc, A.K., 2001; Chacko, E., 2001) suggest that changes in normative beliefs related to gender, marriage and family planning have altered little over the past 20 years. Substantial efforts by India to expand reach and access to family planning services over this same timeframe may be having inadequate effect in rural areas because such improvements in supply do little to affect demand. Son preference and resultant fears of abandonment from women who have not produced a son, a finding demonstrated in other research from India (Stephenson, R. and A.O.Tsui, 2002), highlight the importance of the role of these sociocultural determinants. Programmatic approaches that support delayed first pregnancy, importance of spacing, and equal value of boy and girl children are needed, as well as efforts that reinforce women's right to reproductive control. Prior research from rural India has documented findings from this work related to men feeling that family planning is not their responsibility, but they are the decision-makers regarding the issue and prefer sterilization (NFHS-3, 2007; Raj A, et al, 2011). However, results from this study extend these findings by documenting that men further feel vulnerable to being viewed as emasculated if they are known to support their wives' contraception use. Such findings demonstrate the need for more work on male involvement in family planning and likely require community-level efforts to alter norms that men should not engage in family planning, while simultaneously working with men and couples on shared reproductive decision-making. Engagement with husband's parents, particularly his mother, may also be required to reinforce spacing contraceptive use and husband involvement in family planning, given findings of their role in reproductive decision-making, a finding seen in prior research, as well (Nag, M., 1984; Rajaretnam, T and R.V. Deshpande, 1994; Saavala, M, 1999; Raj A, et al, 2011). Although extensive prior research has documented myths and misconceptions regarding side effects and potential health consequences of hormonal spacing contraception, as well as fears regarding ineffectiveness of these methods (Chaudhury, R. H., 2001; Bongaarts, J. and J. Bruce, 1995; Rani, M. and S. Bonu, 2003; Char A., 2001; Rajaretnam, Tand R.V. Deshpande, 1994; Saavala, M, 1999; Mary Ann Kirkconnell-Hall, Rob Stephenson, Sanjay Juvekar, 2006; N.N. Sarkar, 2008; Ferdousi SK, et al, 2010) such perspectives were less expected as much of this research is a decade old or older. However, numerous side effects were ascribed to the oral contraceptive pill and IUD by wives and husbands; these side effects included nausea, fatigue, abdominal pain, infertility, heavy menstrual flow, and vaginal discharge.

Notably, the described side effects were based on perceptions and hearsay rather than direct experience, and were reported to have impeded their own use of these forms of contraception. Condoms, in contrast, were not described in terms of potential risky side effects but rather as only necessary if there were extramarital affairs and HIV/AIDS; though husbands did report that they had not started or discontinued use due to condoms inhibiting their sexual pleasure or due to difficulties with condom disposal. Condoms remain the most common form of spacing contraception use in India (NFHS-3, 2007), despite their relatively lower effectiveness and current findings indicating their vulnerability to discontinuation. No contraception until desired number and sex of children was achieved, and then female sterilization, remains the norm for this rural population, particularly those from the tribal communities.

While findings from this study offer important contributions to current understanding of barriers to spacing contraceptive use in rural India, they must be viewed in light of several important limitations. The study is limited to a small convenience sample of young husbands and wives, mothers-in-law and providers in a single district of rural Maharashtra, and thus, generalizability of study findings may be limited to this area. However, the study location was selected in part due to the fact that the site's family planning characteristics mirror those trends taking place in rural Maharashtra. Furthermore, while convenience sampling presents methodological challenges in terms of sampling bias, convenience sampling is commonly used in qualitative research methodology to examine formative or pilot data (Martin & Marshall, 1996). Interviews were conducted with research staff and thus are subject to social desirability of responses. Many more stigmatized barriers to effective contraceptive use, such as sexual violence in marriage, may be a concern for this population but were not articulated due to discomfort with the topic. Due to focus on couples' perspectives, the current study did not focus on analysis of the availability of services and supply of contraceptive methods. In addition, lack of audiotaping of interviews and dependence on interviewer's notes for transcription limited the ability for precise transcription. However, research staff are accustomed to this method of qualitative data collection as this is the standard for the field in India (citation). Finally, the study did not focus on forms of contraception currently unavailable in the public health sector, such as injection.

5.0 Conclusion and Implications

This qualitative study of barriers to spacing contraception use in rural India demonstrates that no contraceptive use until desired number and sex of children is achieved, and then female sterilization, remains the norm in rural India. Barriers to change include socio-cultural factors such as expectations early pregnancy in marriage, desire or even requirement for boys, and low reproductive control among women, with husbands and in-laws too often having greater reproductive decision-making control than the women themselves. Additionally, many myths and misconceptions related to oral contraceptive pill and IUD remain, including beliefs regarding severe side effects and infertility. While there were fewer concerns related to side effects from condom use, and greater indication that this form of contraception was at least attempted, discontinuation due to concerns with male sexual pleasure and condom disposal was reported. These findings reinforce the need for targeted spacing contraception promotion in rural India that includes delivery of localized contraceptive services, increase of knowledge regarding the safety and utility of spacing contraception options, improvement of gender ideologies that restrict female choice and control of contraception and simultaneously improve male involvement in family planning, and social norm alterations regarding son preference, early pregnancy in marriage and reliance on female sterilization. Such efforts likely require community education and outreach to men, as well as clinical service sensitivity to these issues.

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References

Athavale AV, Athavale SA. Factors Influencing the Decision to Undergo Tubectomy in a Rural Area of Maharashtra State. Regional Health Forum WHO South-East Asia Region. 2003; 7(2)

Baveja R, et al. Evaluating contraceptive choice through the method-mix approach: An Indian Council of Medical Research (ICMR) Task Force study. Contraception. 2000; 61(2):113–119. [PubMed: 10802276]

Basu AM. Ignorance of Family Planning Methods in India: An Important Constraint on Use. Studies in Family Planning. 1984; 15(3):136–142. [PubMed: 6740730]

Bertrand JT, et al. Access, Quality Of Care and Medical Barriers In Family Planning Programs. International Family Planning Perspectives. 1995; 21(2):64–69. 74.

Bongaarts J, Bruce J. The Causes of Unmet Need for Contraception and the Social Content of Services. Studies in Family Planning. 1995; 26(2):57–75. [PubMed: 7618196]

Blanc AK. The Effect of Power in Sexual Relationships on Sexual and Reproductive Health: An Examination of the Evidence. Studies in Family Planning. 2001; 32(3):189–213. [PubMed: 11677692]

Chaudhury RH. Unmet Need for Contraception in South Asia: Levels, Trends and Determinants. Asia-Pacific Population Journal. 2001; 16(3):3–22.

Char A. Women's Perception of Their Reproductive Health Before and After Sterilization in Rural Maharashtra, India. Asia-Pacific Population Journal. 2001; 16(2)

Char A, et al. Male perceptions on female sterilization: a community-based study in rural Central India. Int Perspect Sex Reprod Health. 2009 Sep; 35(3):131–8. DOI: 10.1363/ipsrh.35.131.09 [PubMed: 19805018]

Chacko E. Women's use of contraception in rural India: a village-level study. Health & Place. 2001; 7(3):197–208. [PubMed: 11439255]

Donaldson PJ. The Elimination of Contraceptive Acceptor Targets and the Evolution of Population Policy in India. Population Studies. 2002; 56(1):97–110. [PubMed: 12102101]

Ferdousi SK, et al. Unmet Need of Family Planning Among Rural Women in Bangladesh. J Dhaka MedColl. 2010; 19(1):11–15. 2010; Link: http://www.banglajol.info/index.php/JDMC/article/view/6244/4815.

International Institute for Population Sciences and ORC Macro. National Family Health Survey (NFHS- II), India 1998–99. Maharashtra. Mumbai: International Institute for Population Sciences (IIPS); 2001.

Janowitz B, Bratt JH. What Do We Really Know About the Impact of Price Changes on Contraceptive Use? International Family Planning Perspectives. 1996; 22(1):38–40.

Liberhan, T., et al. Common Advocacy Plan for Expanding Contraceptive Choice in India. Gurgaon: Futures Group, Health Policy Project; 2013. Link: http://www.healthpolicyproject.com/pubs/173_IndiaCommonAdvocacyPlanFinal.pdf

Lewis MA. Do Contraceptive Prices Affect Demand? Studies in Family Planning. 1986; 17(3):126–135. [PubMed: 3726901]

Mary Ann, Kirkconnell-Hall, Rob, Stephenson, Sanjay, Juvekar. Myths and Misconceptions: Barriers to Reversible Contraception Use in a Rural Indian Village. 2006. Link: http://paa2006.princeton.edu/papers/61439

Marshall, Martin M. Sampling for qualitative research. Family Practice. 1996; 13(6):522–525. [PubMed: 9023528]

Sarkar NN. Department of Reproductive Biology, All India Institute of Medical Sciences, New Delhi, India. Barriers to condom use. The European Journal of Contraception and Reproductive Health Care. 2008 Jun; 13(2):114–122. 2008; Link: http://nclc203seminarf.pbworks.com/w/file/fetch/36460290/Sarkar%25202008.pdf. [PubMed: 18465472]

Nag M. Some cultural factors affecting costs of fertility regulation. Population Bulletin of the United Nations. 1984; 17:17–38.

NFHS-3. National Family Health Survey (NFHS-3) (2005–06). India. Sep.2007 I

Rani M, Bonu S. Rural Indian Women's Care-Seeking Behavior and Choice of Provider for Gynecological Symptoms. Studies in Family Planning. 2003; 34(3):173–185. [PubMed: 14558320]

Rajaretnam T, Deshpande RV. Factors Inhibiting the use of Reversible Contraceptive Methods in Rural South India. Studies in Family Planning. 1994; 25(2):111–121. [PubMed: 8059444]

Raj A, et al. Abuse from in-laws during pregnancy and post-partum: qualitative and quantitative findings from low-income mothers of infants in Mumbai, India. Maternal Child Health J. 2011 Aug; 15(6):700–12. DOI: 10.1007/s10995-010-0651-2

Saavala M. Understanding the Prevalence of Female Sterilization in Rural South India. Studies in Family Planning. 1999; 30(4):288–301. [PubMed: 10674325]

Stephenson R, Tsui AO. Contextual Influences on Reproductive Health Service Use in Uttar Pradesh, India. Studies in Family Planning. 2002; 33(4):309–320. [PubMed: 12561780]

Santhya KG. Changing Family Planning Scenario in India. Regional Health Forum WHO South-East Asia Region. 2004; 8(1)