Side-Effects and Social Norms Influencing Family Planning Use in Nepal

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ABSTRACT

Background

Effective family planning (FP) programs promote modern contraceptives and help individuals achieve their reproductive goals. Despite Nepal's relatively high contraceptive prevalence rate (50%), 27% of married women have an unmet need for FP, and almost half of Nepalese women give birth by the age of 20. This formative study explored the factors that influence the use of contraceptives in Nepal.

Objective

To provide information about barriers to family planning use, general fertility awareness, and barriers to family planning use among difficult to reach groups communities.

Method

This qualitative study was implemented in five districts in Nepal. A total of 36 focus group discussions, 18 participatory group discussions, and 144 in-depth interviews were conducted. Participants included young married women, men and FP service providers in eight village development committees and two municipalities. The interviews were digitally recorded, transcribed in Nepali and then translated into English. Data was organized using Atlas Ti 7 and coded using a thematic analysis.

Result

Four key themes emerged from the analyses: 1) limited knowledge on fertility awareness and family planning methods, 2) religious-cultural factors including social norms impediments contraceptives use, 3) fear of side-effects, myths and misconceptions about modern contraceptives, and 4) structural barriers such as limited family planning services, and lack of same gender providers make it difficult for many women to access modern contraceptives services.

Conclusion

Continuing Nepal's recent gains in contraceptives prevalence rate will require strong educational interventions addressing fertility awareness, social norms around son preference, dispelling fear of side-effects while increasing the family planning method-mix. Health service providers should continue counseling clients on the management of potential side-effects and ensure accurate information about modern contraceptives.

KEY WORDS

Contraceptive prevalence rate, Family planning, Fertility awareness

INTRODUCTION

Family planning (FP) is a valuable practice that enables couples to plan the timing, spacing, family size, and choice of FP method. In Nepal, FP is now an integral part of the national health system. Currently, 49.7% of all Nepalese women, ages 15-49 report using some method of FP (43.2% modern methods; 6.5% traditional methods).[1] Despite Nepal's relatively high contraceptive prevalence rate (CPR) (49.7%), unmet need is estimated at 27% for married women, and 21% of births occur with suboptimal spacing (within two years of last birth).[1] Since 2006 CPR for modern methods has stagnated around 43%, while the prevalence of traditional methods remained low, but nearly doubled (3.7% to 6.5%).[2]

Disparities in CPR and modern method use vary widely by age and ethnicity especially among Janajati, Dalit, and Muslims, who tend to experience higher Total Fertility Rate (TFR) and lower CPR than the national average.[1] These 'Difficult to Reach Groups' (DTR) are categorized because of their limited access to reproductive health and FP services.[3] Reasons for limited FP uptake vary across a range of issues including a lack of understanding of which methods to use; concerns and experience of side-effects; limited availability of FP methods; and a lack of advice and counseling.[4,5]

Similarly, cultural and social norms such as early marriages and son preference are still common practice in Nepal.[6] The impact of these social pressures lead to earlier initiation of sexual activity for young men and women. Studies found that about 17% of adolescent girls in Nepal are already mothers and around 19% of adolescent girls reported an unplanned pregnancy.[1,7] Additionally, stagnating CPR is impacted by male work migration, which has increased from 26% to 32% between 2006–2011.[1] Spousal separation may contribute to decreasing fertility rates and non-use of FP methods over this period. It is believed that women often discontinue FP methods when separated from their spouses to avoid rumors about infidelity mainly from community and because the methods are not needed.[8] Coital relationships among unmarried individuals in Nepal are fairly rare and open discussion about sexual matters is considered taboo.[9] In many rural areas of Nepal, families encourage arranged marriages and discourage adolescent girls from engaging in premarital sex or even associating with boys.[10]

Considering these known challenges, there is a need for tailored interventions to address the programmatic and policy gaps in order to improve FP uptake. The Fertility Awareness for Community Transformation (FACT) project, funded by USAID is being implemented in Nepal by IRH and Save the Children. FACT aims to increase fertility awareness to reduce unintended pregnancies. Fertility Awareness is actionable information about fertility throughout the life course and the ability to apply this knowledge to one's own circumstances and needs.[11] Specifically, it includes: 1) basic information about the menstrual cycle, 2) when and how pregnancy occurs, 3) the likelihood of pregnancy from unprotected intercourse at different times during the cycle and at different life stages, and 4) the role of male fertility. Fertility awareness also can include information on how specific family planning methods work, how they affect fertility, and how to use them; and it can create the basis for understanding communication about and correctly using family planning.[11] Hence, this qualitative study seeks to provide information about barriers to FP use, general fertility awareness, and barriers to FP use among DTR communities.

METHODS

A formative qualitative study was conducted in five districts of Nepal (Bajura, Nuwakot, Pyuthan, Rupandehi and Siraha) from June to September 2015. Eight village development committees and two municipalities "urban-slums" were selected because of their large difficult to reach communities. A purposive sampling technique was used for selecting participants, a method often used in studies interested to learn more about a particular population that uses strict criteria for picking subjects (12). A total of 36 Focus Group Discussions (FGDs), 18 Participatory Group Discussions (PGDs), and 144 In-Depth-Interviews (IDIs) were conducted. Moreover, 18 IDIs with FP service providers were conducted to understand provider's perspectives. This method is often used when the researcher has specific requirements and there is no hard and fast rule for the sample size for qualitative research (12). To comprehensively answer the study questions, three different categories of participants were approached for the data collection: 1) married young women (ages 15-21 years') who belonged to Dalit, Janajati, Muslim and Chhetri (Chhetri specifically within remote areas of the Bajura district) ethnic groups, 2) married men from the DTR communities who were married to women ages 21 and younger, and 3) health providers of the respective communities.

Interviews were conducted with the aid of an interview checklist and included probes to further questioning, covering questions on the concepts of fertility awareness, family planning and its use (Box 1).

Box 1. Questions consist of fertility awareness and FP

Fertility Awareness:
- What do women and men know about fertility (e.g., risk of pregnancy, observable signs of fertility, post-partum fertility)?
- How does fertility awareness relate to FP use?
- What are cultural beliefs and practices around fertility and menstruation?

Family Planning:
- What do women and men know about FP methods?
- How do women and men communicate about FP?
- How accessible is FP among women and men?
- What social norms govern communication on these topics (such as gender or age barriers)?
- What are the barriers and facilitators of FP use among women and men?

The interviews were conducted and digitally recorded after completing the consent process in Nepali. Sessions lasted 60 to 90 minutes. All the interviews were recorded using digital voice recorders, and field notes were also taken for post discussion reference. Audio-recordings were transcribed verbatim in Nepali and then translated into English. The data were organized using Atlas TI-7 and coded using a thematic content analysis.[12-14] Data accuracy and quality of translations were maintained through periodic monitoring and cleaning by team leaders and onsite supervisors. Main themes were cross-referenced with the study research question, to ensure that emerging themes informed key areas relevant to the study. The quotations cited in this paper best represented the range of ideas voiced around key themes to maintain anonymity these quotes are identified by district, gender and service providers position.[14] This study received ethical approval from the Georgetown University's Institutional Review Board and the Nepal Health Research Council (NHRC) prior to data collection. Written consent was obtained from all the participants in a private setting and illiterate participants consented with a witness present (i.e., a person who knew the participant, could explain the consent form, and was themselves literate.[15] Voluntary participation and freedom of refusal at any stage of the session was emphasized prior to data collection.

RESULTS

This paper covers the four key themes from the thematic analyses, which are: 1) knowledge on fertility awareness and FP methods, 2) socio-cultural factors including social norms around son preference, 3) participants' knowledge of FP methods, and 4) structural barriers to use FP services.

Knowledge of Fertility Awareness

Overall, participants had limited knowledge of male and female fertility. When queried about specific issues, such as onset of male and female fertility, the fertile window of the menstrual cycle or post-partum return to fertility, many participants had limited knowledge on the subjects and lacked details that would allow them to apply the information successfully to their own FP needs.

"There is a high probability of conceiving after 13 years of age and woman can get pregnant from menarche until 40/45 years and between these menstruation cycles, I think 7 to 11 days after menstruation is an unsafe period" (IDI-Woman, Pyuthan).

There was some misunderstanding of the length of the fertile window during every cycle but most participants described when fertility begins. Universally, participants reported that when a girl reaches menarche, she is able to be a mother.

"When a girl has menstruation, we understand that she is mature enough to have child" (FGD-Men, Rupandehi).

Additionally, service providers were able to identify safe and unsafe periods during the menstrual cycle without issue.

"In safe period" there is a concept of 14 days plus minus 4 days after the menstruation. We need to avoid sexual activity in that period or use the device if you want to have sex. It is difficult to know the exact date of fertile period" (IDI-Service Provider, Pyuthan).

Most participants understood that a woman's fertility changed over the course of both her life and her menstrual cycle; however, few could identify times of high fertility or low fertility, and none accurately estimated the duration of the fertile window.

"Those who do not have their menstruation will not bear children. After menstruation pregnancy occur." (FGD-Women, Nuwakot)

"The high chance of getting pregnant is during the 7th day of menstruation to 20th day." (FGD-Women, Bajura)

Similarly, participants were able to explain male fertility. Participants accurately described, male fertility beginning in early adolescence and extend throughout the life course. Knowledge of how boys know they are fertile was inaccurate and often tied to an age.

"After 13 [years of age], they start releasing sperm. As soon as they start releasing sperm, it should be understood that they can make a woman pregnant." (FGD-Men, Siraha)

"Man can produce children at any time. If he is not able to make the women pregnant even after having sexual contact, then he is infertile." (FGD-Men, Bajura)

However, male participants were not well versed on how fertility is affected after childbirth or determining pregnancy risk at different points of the menstrual cycle. Participants suggested that a woman could conceive a child the day after giving birth.

"She can conceive from next day of delivery of child if she has sex." (FGD-Men, Rupandehi)

Men described situations of assumed female infertility based on lack of conception.

"The maximum age of getting pregnant is 35 years. After 35 years, women may not be able to get pregnant." (FGD-Men, Bajura).

Family Planning Knowledge and Use

Almost all participants could identify several methods of FP, but the information they shared was limited and not specific about the methods, such as how a method worked to prevent pregnancy, or its strengths and limitations.

"I know the devices that is placed in the arm [referring to implant], that is kept in the uterus [referring to IUD], three-month injection [referring to injectable], and medicines [referring to oral contraceptives]." (IDI-Woman, Pyuthan)

Condoms and injectables were the most commonly identified, used, and frequently preferred methods of contraception due to convenience and availability. Some women did report having to travel long distances to obtain injectables.

"Condom is good. Injectable are painful, while condom is not painful. We need to go far to get an injection, but condoms are available everywhere" (IDI-Woman, Siraha).

Interestingly, providers reported that condoms were less acceptable among men due to the lost sexual sensation. This description was not supported by the men interviewed in this study.

"In my understanding, in our male dominated society, men say, "I don't like to use condom. I will not use as it doesn't feel good to use it." They ask women to use family planning devices" (IDI-Service Provider, Siraha).

Long-acting reversible contraceptive methods (LARCs), such as IUCDs or implants, were also identified by many participants as acceptable methods, though few were familiar with their correct names or duration of action. Many participants reported that LARCs were available in some health facilities, but not easily accessible if you are in a remote area.

"Copper-T, IUCD are not available here [health facility], we have to go to city to use it. I had decided to use that device, as it works for 5-8 years. If we don't go there to receive that service then health workers won't come here to provide service. If we go to city, it will affect my work. That's why I have decided that until I have free time, I will use this [a short-term method]" (IDI- Woman, Nuwakot).

Very few participants were familiar with the fertility awareness-based methods (FAM) and those who identified using a natural FP method chose the method because of the unavailability of modern methods. Participants stated that the most common natural method was withdrawal though they appeared to practice withdrawal due to convenience rather than as a preferred method.

"There is not any such specific reason for using withdrawal method. The health provider is far, so I don't like to go there. Therefore, we [couple] thought that this method would be suitable for us and we have been using this method [withdrawal]" (IDI-Woman, Nuwakot).

Service providers also explained that those who have difficulty reaching a facility, can practice natural family planning. *"Difficult to reach group may use natural method like throwing semen outside [withdrawal method] because they might not be getting other devices" (IDI-Service provider, Bajura).*

Some participants also explained that they were practiced exclusive breastfeeding, although the specific requirements of Lactational Amenorrhea was not clear in responses.

"If more milk is fed to the child then pregnancy does not occur but if less milk is fed to child then pregnancy can occurs" (FGD-Women, Bajura).

Religious and Cultural Challenges

Religious and cultural barriers also played a role in preventing FP use. Muslim participants, in particular described FP as something that is not within the guidelines of Islam. Additionally, providers noted that specific contraceptive methods that require injections, incisions or insertions, such as injectables, intrauterine contraceptive devices or implants were unacceptable to Muslim women.

"There is a concept that if Depo-Provera [injectable] is used, then service providers will see upper arm and buttock. Their religion doesn't allow them" (IDI-Service Provider, Siraha).

Female participants from Rupandehi also expressed that there are religious challenges associated with FP use. This is also corroborated by health service providers, who acknowledged the challenges in accessing FP services in various communities.

"I have heard that after death of people God will ask for the part of the body that he sent without any scar and cuts. So I have not seen people getting operations. No one ever does. In our caste, no one does. I have not seen my relatives either. People just take medicine and use injection. Everyone use injectable and pills, but don't undergo operation" (IDI-Woman, Rupandehi).

"Those people who use family planning devices in the Muslim communities do not inform in their house. Muslim people come here [for family planning services] secretly" (IDI-Service Provider, Rupandehi).

Some female participants believed that God directly influences the health and birth of a child and that God will be happy if they have multiple children.

"God gives baby. And yes I do trust in god. People used to say bad things about me when I didn't have a child. But god gave me a child" (IDI-Woman, Siraha).

".....we want Allah to be happy and fulfil our wish. We will hope that Allah will give children to us" (IDI-Woman, Sirha).

Participants described distinct differences in FP use among couples who are in migratory relationship compared to relationships where both partners reside in the same home year-round. In Nepal, male migration can occur anywhere from 1-2 months, up to 18-24 months, depending on the type of work, location of the home district, and opportunities presented to men for employment. The pressure of negative perceptions from the community directly influences a woman's decision to discontinue a FP method until her husband returns.

"They comment that she has been using such temporary devices even when her husband is not around and suspect that she is not pure and have another sexual partner" (FGD-Women, Pyuthan).

Participants reported that disclosure of continued FP use could result in shaming and stigmatization within the community, along with suspicions of adultery.

"People of society would gossip about the person who has used FP devices and doubt his behaviour. They look suspiciously thinking that he might have used it (condom) away from the house as well" (IDI-Man, Pyuthan).

Social Norms around Son Preference

Participants spoke of the pressure from family members, particularly mothers-in-law (MILs) to conceive right after marriage and to also have more children than the couple desired. Participants noted that some MILs scolded women for secretly using an FP method and made their life difficult after discovering their use.

"One day, while I was arranging my bed, pills fell down and my mother-in-law saw them. Then she threw it away after seeing it and scolded me. She said that it shouldn't be taken without having first child. After that, I haven't taken it [pills] ever" (IDI-Woman, Nuwakot).

"It is not acceptable in the community because our community has the belief that the newly married couples should have children soon" (FGD-Women, Bajura).

"I know a man who does not want his wife to use FP device. His wife used to come to take Depo-Provera, hiding it from him. I provided her Depo-Provera and sent her home. We didn't tell her husband about it. Later, he knew about it and he took his wife home by pulling her hair" (IDI-Service Provider, Rupandehi).

Frequently, mothers-in-law may have the final decision in spacing and timing of children, as their role in the family can supersede even that of the husbands'.

"I want to use FP device, but my in-laws do not let me use the devices. They want me to have 3 to 4 children. Therefore, they do not let me use" (FGD-Women, Siraha).

Some female participants also described palpable negative pressure on women who did not produce a son. This negative pressure was also wielded by some husbands who threatened their wives with abandonment if she did not give birth to a son. Facing this adversity, many women acquiesce to having additional children or to having children immediately after marriage. They hope to avoid negative reactions from family members and the community.

"If I won't give birth to son he tells that he would marry again. Many of them leave their [first] wives if she doesn't give birth to son" (PGD-Women, Siraha).

Men also agreed that women have pressure on them to give birth to a son.

"There is definitely pressure for a son. In our case, as per Hindu religion there is the belief that one gets salvation and goes to heaven only when the son performs certain ceremonies after parent's death, hence [having] a son is a must" (IDI-Man, Rupandehi).

Men frequently stated that they were the final arbiters of major decisions, including the timing and spacing of children. Some women participants reported experiencing marital conflicts and domestic violence over FP use, while others reported hiding injectable use specifically to avoid conflict with their husbands.

"In our society, they suspect about infertility, if a child is not born within 1-2 years of marriage. If they say hurtful things. The people around my in-law's home said such things to her [my wife] and she cried; I also felt bad. She told me that because people say such negative things, she wanted to have a child; I agreed and we had a child" (IDI-Man, Rupandehi).

Side-Effects and Misconceptions Associated with FP Use

Fear of side effects and misconceptions over FP method side effects were two barriers to FP uptake reported by several participants. Actual side effects, such as pain, dizziness, nausea, weakness, loss of appetite, severe menstrual bleeding were stated as deterrents to using FP methods. Participants did not indicate whether side effects were manageable or dissipated over time.

"I do not want to use FP methods which caused me pain in the stomach and dizziness after taking it" (IDI-Women, Pyuthan).

"There will be pain in the stomach, damage in the lower abdomen and dizziness in head. That's why I don't want to use [Family planning method]. Due to regular bleeding I stopped to use it." (IDI-Women, Siraha).

"Because of side effects, some women are having heavy bleeding which has led to the discontinuation of services." IDI-(Service Provider, Nuwakot).

Specific FP methods, such as injectables were linked with negative side-effects such as, injectables. The side effects were attributed to method discontinuation and switching which may have fueled community-level fear related to the method.

"Women are scared to use Depo-Provera [injectable] because they heard it causes heavy bleeding" (FGD-Men, Bajura).

Misconceptions about FP methods' side-effects included the accumulation of blood clots in the stomach, wounds in the uterus due to heavy bleeding, sterility, infertility, and loss of libido.

"If we use Depo-Provera [injectable] or insert copper-T, we don't have menstruation for 1-1.5 years. All the dirty blood gets collected inside [the uterus] and causes diseases. There will be tumor and one needs to undergo operation. So we find condom appropriate" (IDI-Women, Rupandehi).

Other women stated experiences with IUCDs falling out of the uterus, women needing an operation due to

injectable use, blood impurity and other physical problems. Throughout these responses, a general lack of accurate information about side-effects and their management was apparent.

"If women uses IUCD then there is possibility that it might fall down if a women is working and carrying heavy load" (FGD-Men, Bajura).

"If people take injection and tablets, then blood becomes impure"(FGD-Women, Siraha).

"If injectable is used; later child may not be conceived. Like, blood gets collected in stomach and we may get fat. It may suit to some and may not suit to some. Women said these things, so I was afraid to take medicine or get an injection. Therefore, we used "condoms". I was scared when I heard these things" (IDI-Woman, Rupandehi).

"People perceive weak and difficult for work and walk after doing surgery (Minilap and Vasectomy]" (IDI-Service Provider, Bajura).

Providing clear information on the side-effects of hormonal methods and helping women differentiate between side-effects and misconceptions are essential components to improving FP uptake in Nepal.

Structural Barriers

Lack of FP method supplies and limited healthcare infrastructure were frequently discussed as challenges to FP use. Participants also described instances when health service providers did not provide detailed information about FP methods. This combination of issues were particularly relevant for participants who lived in remote areas and reported traveling long distances to access FP services.

"They don't provide information sir. They just provide whatever is asked but not explain anything more" (IDI-Man, Bajura).

"We have one health post in our village. Every doctor and nurses are known faces here. People in the village are shy, so they do not want to get the [FP] device from there. Instead, they go to the pharmacy to buy condom by spending 10 rupees" (FGD-Men, Siraha).

Challenges were not only associated with the distance of facilities, but unfamiliarity with the health staff, procedures, and high price of services were also deterrents. Several participants described being too shy to discuss sex and/or FP methods or approach a health worker about services, especially if they were the opposite sex and from the same community.

"It will be better if there was a female doctor for women and male doctor for men. We feel shy going to a male doctor and there is possibility that male doctors may even rape us" (IDI-Woman, Bajura).

Several women stated their interest in utilizing services from community level providers like FCHVs but reported that FCHVs only provide short-term methods (i.e. condoms and the second cycle of oral pills). However, a majority of the health facilities distribute condoms, oral pills, and injectables while very limited facilities have long-acting methods (i.e. IUCD and Implant).

"We do not have enough space and room at this health post. There is only one room, which is difficult to give Depo Provera to woman when there are other men [in the room] as well" (IDI-Service Provider, Siraha).

Health service providers further explained that limited space in health facilities hinders their ability to provide quality counselling services.

"When couples come and want to talk in privacy, they cannot say in public. In such a situation I feel difficult. If there was a separate room, then I could keep it confidential. I could provide them the service. People would trust me but we don't have facility here" (IDI-Service Provider, Nuwakot).

"We don't have separate counselling room available for providing counselling and FP services. If any client want to discuss separately and need to provide counselling we don't have separate space and client hesitate to discuss us"(IDI3-Service-Provider, Pyuthan).

DISCUSSION

The results revealed that most participants had some understanding of general fertility, with limited ability to apply this information to their fertility desires. There are gaps in their understanding of a complete FP method-mix and particularly how each FP method work. It appears that gaps in knowledge combined with religious and social/cultural norms are key barriers to contraceptives use in those difficult to reach communities and similar findings were reveled upon further analysis of the NDHS data.[16] Opportunities to combine fertility awareness methods with user-based methods could have positive results among couples particularly in areas with limited access to methods, if individuals are able to apply their fertility knowledge in using an effective method.

Our findings suggest that many Muslim participants noted that FP is as not supported by Islam. This is not a new finding, as another study found that one in every ten Muslim women believes that the Quran prohibits the use of FP services.[3] Supporting this notion, a the Nepal Household Survey (2012) found a 10% CPR for modern methods among Muslim women compared with 41% for other ethnic group across Nepal.[17]

Identifying ways to increase access to and demand for services among Muslim communities will require the use of both service delivery interventions and messages that provide examples in the Quran that support FP use and limiting family size for overall family and community health benefits, as identified in previous programs and research.[18]

In these programs, FP is often framed in context to basic Islamic teachings of moderation and equality. The Quran emphasizes that families are to treat all their children equally and therefore couples should plan to be able do so (16). Thus, the "broad consensus is that family planning is permissible within Islam".[19]

Furthermore, our findings reveled that social norms around son preference greatly impacted FP use, and similar research findings in Nepal, India, and Vietnam also show the significant impact of this social norm on fertility and contraceptive choice.[20-22] This study found that social norms, particularly when enforced by mother in laws and husbands, placed negative pressure on women that went beyond FP use. Mother in laws' desires for grandchildren, in particular grandsons, resulted in some women having more children, than initially indenting to or delay their next pregnancy. Research suggests that the pressure to have at least one son becomes heightened at very low levels of fertility, even in contexts where boy and girl children are generally treated equally.[23] Interventions that address the nuances of son preference will contribute to improving the health outcomes for women.

Gender norms and roles within couples were found to be major barriers to contraceptive use in this study. In Nepal, both men and women stated that because the husband is the primary decision-maker regarding FP, having his approval was a key determinant to using an FP method.[24] Some male engagement interventions can help to improve the frequency and strength of couples' communication around family planning, increase shared decision-making and improve gender equity in relationships.[20,22] These interventions emphasize activities that challenge existing gender norms, educate partners on methods and how they work, as well as facilitate development of communication skills.[25,26]

There are additional challenges to couple communication when a husband is migrating and the only link between couples is a phone. Health interventions in Nepal should increase their understanding of how migration impacts health behaviors of women while their husbands are away. Considering the potential for negative influence between MILs and women with migrating partners, implementation science research should begin to unpack ways to maximize access to reproductive health services for these particular women.

Fear of side-effects, myths and misconceptions of hormonal methods accompanied by limited information were widely discussed as a major concerns for FP interventions, in this study as well as previous studies.[4,5] Findings show that some specific methods like Injectables were linked with negative side-effects. These side effects were attributed to method discontinuation and switching due to negative experiences, while some cited nonuse due to myths and misconceptions. Studies in developing countries, including Nepal show comparable fears and misinformation about FP, although some expressed fears could be linked to real side-effects.[23,27] Women who received high levels of information about contraceptives and management of side-effects are more likely to continue using contraceptives.[27] Several service delivery and quality of care related issues were also identified by participants including no same-sex providers, limited number of long-acting contraceptive services, and no separate counselling rooms at the health facilities. All of these grievances were identified as barriers to FP use. Similar issues were also identified in other studies elsewhere in Nepal.[28,29] It shows that service quality is an important determinant of use of clinical contraceptive methods in Nepal.

CONCLUSION

While most individuals within the target groups demonstrated interest in fertility awareness and family planning but challenges still remain to support contraceptives uptake within difficult-to-reach communities. Couples in migratory relationships face unique challenges because cultural and gender norms put pressure on women to discontinue using a method when their partner is away. Simply promoting family planning use is not enough, thus education about fertility awareness is also necessary for better adherence to contraceptives. Programs that increase fertility awareness should be designed to continually advocate for the acceptance and use of contraceptives by all couples. All health facilities should have gender specific service providers to make clients more comfortable in seeking FP services. Disseminating fertility awareness messages to a society where there is a strong preference for sons is essential (i.e. sex of child is determined by the sperm, not the ovum) and dispelling concerns, myths, and misconceptions of modern contraceptive methods is critical so that both men and women are able to make informed decisions around family planning. Community-based family planning services should be introduced to those difficult to reach communities, which may play a paramount role in increasing the access of contraceptives to the community. Service providers need to be encouraged and provided with the necessary training and motivation to effectively promote family planning services in health facilities on a regular basis. Ministry of Health in coordination with I/NGOs involved in family planning, have to work together in order to increase the accessibility and availability of all modern contraceptives methods at health facilities in various communities.

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