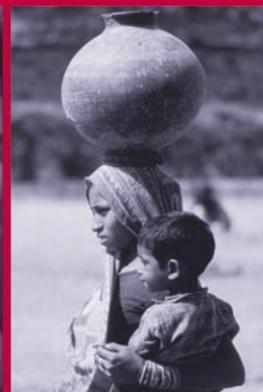


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PERSPECTIVES ON BIRTH SPACING IN FIVE COUNTRIES

BOLIVIA, EGYPT, INDIA, PAKISTAN AND PERU

2004



CATALYST
consortium

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**As Reported by Women, Men, Mothers-in-Law and Health
Care Providers**

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LIST OF ABBREVIATIONS

| | |
|--------|--|
| CAs | Cooperating agencies |
| NGO | Non-governmental Organization |
| OBSI | Optimal Birth Spacing Initiative |
| RH | Reproductive health |
| USAID | United States Agency for International Development |
| UNICEF | United Nations International Children's Fund |
| IUD | Intrauterine Device |

I. INTRODUCTION

The Optimal Birth Spacing Initiative (OBSI) is an effort supported by CATALYST Consortium to place optimal birth spacing on the global public health agenda with the recommendation of three to five year birth intervals at the policy, programmatic and behavioral levels. OBSI has three objectives: (1) to create consensus among international organizations and program managers on the strong association between birth intervals of three to five years and improved maternal and child health; (2) to strengthen health services, health care provider training and community programs with birth spacing programming; and (3) to empower individuals and families to adopt optimal birth spacing behaviors. To collaborate on the Initiative, CATALYST has facilitated the formation of a group of “Birth Spacing Champions” (Champions) as an ongoing working group, including over 30 representatives from USAID, UNICEF, cooperating agencies (CAs) interested in birth spacing issues, nongovernmental organizations (NGOs), and academic researchers.

OBSI developed its solid statistical framework based on the quantitative research on the health outcomes of the lack of optimal birth spacing which was commissioned by CATALYST. This research shows that when births are spaced three to five years apart there are substantially more health benefits for neonates, infants, children and mothers than the previously recommended two-year birth spacing interval. Research findings from North America, Asia, the Middle East/North Africa, Latin America/Caribbean and sub-Saharan Africa have shown the following:

- Short birth intervals are a key risk factor for maternal and perinatal morbidity and mortality. This effect remains when the data are statistically controlled for sociodemographic and biological variables (Conde-Agudelo and Belizan, 2000; Fuentes-Aflick et al., 2002; Zhu et al., 1999; Zhu et al., 2001).
- The lowest perinatal mortality occurs with birth intervals between three years and 47 months, and the fewest miscarriages occur when birth intervals are between two years and 35 months (Rutstein, 2002).
- Women with birth intervals of less than 15 months, have 2.54 times the risk of maternal death compared to women with birth intervals of 27-32 months. Women with long birth intervals (greater than 69 months or 5 years 9 months) have a higher risk for adverse maternal outcomes, such as preeclampsia and eclampsia (Conde-Agudelo and Belizan, 2000).
- In Latin America adolescents aged 15-19 years comprise 80% of the group with the shortest birth intervals. Adolescents who are 16 years old are four times more likely to die of pregnancy related causes compared to mothers aged 20-24 years. Infants of these mothers face an increased risk for low birth weight, small-for-gestational age and preterm delivery (Conde-Agudelo, 2002).
- There is a substantial demand for birth spacing among young and low-parity women, and a demand among zero-parity women to delay their first births (Jansen et al. , 2002).

As part of the OBSI strategy, CATALYST also commissioned qualitative research in order to better understand the many and complex issues that shape reproductive health and birth spacing behaviors. Focus group studies were conducted in five countries: Bolivia, Egypt, India, Pakistan and Peru. Findings from the focus groups provide a foundation for developing optimal birth spacing information, counseling materials and the health care providers' training guides.

II. METHODOLOGY

Historically, strong statistical data regarding birth spacing has been available mostly from hospital-based studies. However, very little was known of the thoughts and opinions of men and women on how, as couples, they make their decisions about birth spacing, what methods they use to practice birth spacing and what factors influence their spacing decisions. The CATALYST Consortium developed a Focus Group Session Guide (Guide) and contracted with research firms and individual researchers to conduct focus groups. The Guide was used to conduct 173 focus groups held in five countries: Bolivia (24), Peru (24), India (34) and Pakistan (40) and Egypt (51). (See Table 1)

The Guide was designed to determine the following information on the participants. Their knowledge of birth spacing, their perceptions of family and traditional norms, the roles of their partners in the decision-making process on birth spacing and their perceptions of the advantages and disadvantages of birth spacing for women, men and children. Participants were also asked about the roles played by religion, service providers and pharmacies in birth spacing and their most trusted sources of information on birth spacing.

Women participants were classified as “spacers” and “nonspacers”. Spacers were defined as: (1) women whose children are spaced at least 24 months (two years) apart, as measured from the birth of one child to the birth of the next child; (2) women whose youngest child is at least two years old, but who still want more children; or (3) women whose last child is less than 15 months old, but who are currently using a contraceptive method with the purpose of delaying another pregnancy. Nonspacers were defined as: (1) women who have a birth interval between two deliveries of less than 24 months (two years); (2) women who have a child less than 15 months old and who are not currently using a contraceptive.

Participants were then divided into five categories: women spacers and nonspacers, men, healthcare providers, and mothers-in-law. (Researchers in India and Pakistan added the category of mothers-in-law because, in these countries, mothers-in-law strongly influence birth spacing decision-making). Focus groups were held with groups from each of these categories except in Bolivia and Peru where the role of mothers-in-law is no longer considered a determinant. Because studies indicate that developmental differences, work status and reproductive health experience, influence the number of children a woman has, women and men were divided into two age groups: 15-19 years and 20-35 years. Most mothers-in-law were all in one age range, and the selection of health care providers depended on their willingness to participate, so that age was not a relevant factor.

More than 1,300 people participated in the focus groups discussions, organized as follows:

Table 1. Focus Groups Distribution by Country

| Country | Areas where focus groups were conducted | # of focus groups conducted | Categories of participants |
|-----------------|---|-----------------------------|--|
| Bolivia | El Alto de La Paz and Cochabamba | 24 | <ul style="list-style-type: none"> • Women who have practiced birth spacing: Ages 15-19 and ages 20-35 • Women who have <i>not</i> practiced birth spacing: Ages 15-19 and ages 20-35 • Male partners: Ages 15-19 and ages 20-35 • Health care providers: As found • Mothers-in-law: As found in India, Pakistan and Egypt only |
| Egypt | Cairo, Sohag and Minia | 51 | |
| India | Delhi and Panipat | 34 | |
| Pakistan | Lahore, Karachi, Gujranwala and Thatta | 40 | |
| Peru | Lima, Huanuco and Tarapoto | 24 | |
| . | Total number of focus groups conducted: | 173 | |

III. COMMON FINDINGS

Even though there are differences in the findings of each country, there were beliefs, information, perceptions, barriers, and practices regarding optimal birth spacing that were common throughout these countries. These are the following:

Concept of birth spacing

In all countries, the majority of participants understood the concept of birth spacing, but there was no consensus on how long the interval should be.

Positive attitude towards longer birth spacing

Focus group participants concluded that births should be spaced at least two years apart based on the perceived benefits listed below. Participants in Pakistan, Egypt and Peru felt that three years was the optimal interval. A majority of women felt that about five years was an optimal maximum interval, with women in Pakistan and Peru saying exactly five years.

Perceived benefits of birth spacing

- **For the mother and already born child**
 - In all of countries, women, men and health care providers believed that spacing was important for the emotional and physical health of the woman and for the welfare of the children.
 - Women believed they would have more time to dedicate to their children and their own personal development if they had fewer small children to care for at one time.
 - Health care providers noted that children who were too closely spaced could suffer multiple negative health effects and be emotionally and nutritionally deficient.

For the men

- Men felt that having children with longer spacing intervals would allow their partners to have more time to care for them and reduce the household expenses.

- **For the family economy**

In all countries, economic stability was offered as one of the primary reasons for spacing. With fewer children at one time, families had more resources for each child.

Common barriers impeding practice of optimal birth spacing

- **Mother-in-law pressure**

Women from Pakistan, India and Egypt tend to live in extended families in which mothers-in-law negatively influence birth spacing. One Pakistani woman said, "Women have no say at all. It all depends on the mother-in-law."

- **Cultural beliefs with gender inequity**

Focus Group participants from every country said that husbands exercise a great deal of control over whether a woman practices birth spacing. For example, in Bolivia women said they were pressured into having sexual intercourse, and that men often did not consider the fact that they could become pregnant.

Both health care providers and women also said that men had control over sexual decision-making and would assume that their wives were being unfaithful if they used a birth control method. In all countries, the support of the husband was considered to be one of the most important enabling factors for spacing. In all of the countries, women and men also said there was almost no dialogue or conscious decision-making regarding the next pregnancy.

- **Religious stand**

Islam, Catholicism and other Christian religions tend to favor birth spacing, but some also prohibit the use of modern contraceptives as the means of practicing birth spacing.

- **Knowledge and beliefs regarding contraceptives**

- Local beliefs about contraceptive methods also proved to be a significant barrier to contraceptive use, whether it was a lack of accurate knowledge about correct use or a dislike of the side effects. For example, in Peru, one woman reported that she stopped taking pills while breastfeeding because she feared that it would affect her baby boy.
- Providers in Peru also reported that postpartum women would not initiate use of a contraceptive until after their "periods" had returned – when they were already fertile. In Bolivia, some women believed that IUDs caused cancer. In Pakistan, women believed that they could become ill from practicing family planning.

- **Lack of access and follow up in use of contraceptives**

In some cases women reported lack of access to contraceptives as a reason for not spacing.

- **Economic considerations**

Findings showed that in India and Pakistan, Islamic law allows husbands to leave wives who fail to reproduce, and does not require that they provide economic support for the women afterwards. Therefore, women from these countries desire to have children and do not wish to restrict births

- **Limited OBSI knowledge among health care providers**

Health care providers cited a lack of clear policy on birth spacing from the Ministry of Health authorities which resulted in different providers giving different recommendations, creating confusion among their clients about the optimal birth interval

IV. PRESENTATION OF RESULTS

A. The Concept of Birth Spacing

The majority of participants in the five countries had their own understanding of birth spacing before taking part in the focus groups. Different terminology identifies the birth interval in different countries: in Peru it is “the waiting period,” in India, “the gap between children” and in Bolivia, “to rest after giving birth or to be careful, take care of yourself (*cuidarse*).” There was not an obvious agreement on the length of time the interval should be. The majority of women in the younger group, even nonspacers, agreed that the birth interval should be about three years. The majority of participants indicated that an interval of less than two years was considered to be too short. Participants in India, Pakistan and Egypt predominantly felt that about three years was the optimal birth interval. However, in actual practice, there was an interval of less than two years. A majority of women participants said that about five years was a good maximum birth interval, with those in Pakistan and Peru explicitly stating exactly five years.

Focus Group participants expressed an overall positive attitude towards a recognized and accepted optimal birth interval of three to five years, indicating that a three to five year interval between births would be widely acceptable to women and men in the population at large.

B. Perceived Advantages of Practicing Optimal Birth Spacing

The majority of women, men and mothers-in-law could identify specific benefits from spacing births for the health of the mother, the child, the father, and the next child to be born.

Advantages for Women

The advantages of birth spacing for women were physical, mental and economic. They could expect better health, had more time for themselves, and had fewer demands on limited finances.

- Women stated that birth spacing allowed them more time to recuperate from giving birth.

“...more spacing gives a woman time for personal care ...”

(India)

- Women said longer birth intervals would give them more free time to engage in income generating activities, which they could not do when children were too closely spaced.

“The woman wouldn’t suffer, she would work less, would have to make less of an effort. She could also study, work and do other things.”

(Bolivia)

- Peruvian women from ages 13-19, who focused on their personal development, said that birth spacing enabled them to finish their studies and improve their lifestyle.

“My mom told me to study first and to get ahead. She said you suffer with a lot of children.”

(Peru)

- Pakistani women said birth spacing lets them sleep better, gain strength and relax.

“If she does not sleep or rest properly she will not be able to look after her children”.

(Pakistan)

- Indian women cited overcoming anemia as an advantage of birth spacing.

“Mother looks after her diet...no anemia...”

(India)

Advantages for men

- Men also vocalized advantages for women who spaced births. One man from India put it very graphically:

“...not good if one is in her lap and one is taking feed. Better if one is walking and one is feeding. That looks good...” (India)

- Adult men identified economic benefits to the family if the women did not have another pregnancy too soon because of pregnancy related expenses and additional costs for each new child for food, clothing, etc. Younger men in Peru believed that the woman would have more time to work, generating income if she spaced births.

“She could have more time to work, and so help her partner with the expenses.”

(Peru)

- An advantage of birth spacing for men in Bolivia was that women could give them more attention by not having to take care of two very young children at the same time.

“The wife has more time to take care of us.”

(Bolivia)

- Women explained that having the babies spaced farther apart would allow more time to improve the relationship of the couple.

“Because we take care of the children, we don’t have time for ourselves and we are exhausted and so our husbands get bored.”

(Peru)

Advantages for the last child and the next to be born

There are also perceived advantages that result from the increased length of time a mother can dedicate to a newborn. If the mother is already taking care of a child under the age of one, or if she is pregnant again, she will have significantly less time to spend caring for the newborn.

“If a second child comes after a gap (birth spacing) the first child gets better affection.”

(India)

- Participants believed that the added attention to the newborn child enhances his or her psychological and nutritional status.

“The child can receive better care, as well as more attention and affection, because he does not need to compete with another child that is born when he is still very young.”

(Peru)

Advantages for the family’s economy

- Participants acknowledged the economic benefits of birth spacing also due to the multiple expenses of a new pregnancy and a newborn.

“We won’t suffer because of the expenses; the economic situation will be better.”

(Peru)

“Money can be collected for two years and finances brought under control.”

(India)

- All of the participants indicated they were able to save money for daily expenses if they practiced spacing. However, if the children were too close in age, the income would only cover expenses and not leave any extra for the parents or for savings.

- In general, women perceived that there would be more financial resources available for the family expenses if the babies were spaced further apart.

“Men get free from all tensions. You know it costs a lot for a delivery and it is also very costly to raise children”.

(Pakistan)

C. Perceived Disadvantages of Practicing Birth Spacing

Men's perceptions

Men usually expressed the disadvantages practicing birth spacing primarily in regards to sexual activity. Men said they would have to adjust to lower levels of sexual activity in order to avoid pregnancies. Many men said they would prefer that their partner not practice birth spacing rather than have less sexual activity. These opinions are based on the assumption that their partners were not using a contraceptive method and thus they would have to reduce the frequency or timing of sexual intercourse in order to avoid getting pregnant.

Women's perceptions

A common disadvantage expressed by women was the fear that if the decision to use contraceptives for birth spacing was not a mutual decision, and if the man discovered she was using a contraceptive, the woman would risk having a jealous or violent reaction from him.

*"I used contraceptives but I had to stop. He got too jealous."
(Peru)*

Providers supported this idea.

- Many women also preferred in closely spacing children because the children can have each other's companionship. They perceived that children born too far apart couldn't relate and play with each one another as easily as if they were close in age.

D. Actual Birth Spacing Practices

How to calculate birth spacing

The term birth spacing can refer to either the interval between pregnancies – the time between the birth of one child and the conception of the next child, or the time between the birth of one child and the birth of the next child. In all five countries women, men and providers agreed that it is easier for a woman to calculate when she should plan to get pregnant again after the birth of her last child rather than when the next child should be born. This is called the inter-pregnancy interval

To calculate the inter-pregnancy interval, women simply count from the birth of the last child when they want to begin the next pregnancy. The calculation of the optimal birth interval taken to an extreme requires that spacers calculate the optimal birth time for the next child by counting forward three years after the birth of the last child and then subtracting nine months for the pregnancy to find the exact month and year when she should get pregnant so that the new child is born after the optimal interval. In most countries this is too complicated and cumbersome a calculation to put into practice. It taught this way, birth spacing may be less successful.

Gap between knowledge and practice

There is a discrepancy between women's knowledge of optimal birth spacing practices, their wishes to follow them and the reality that many closely spaced pregnancies still occur. This disconnection, according to focus group findings, involves many factors, among them the husband's decision about sexual activity:

- Women said that men frequently misinterpret their wish to space births as possible infidelity or loss of love. Many men who think this way prefer that their wives refrain from using contraceptives, which leads to a higher rate of pregnancy.

"...they [men] think we are unfaithful....that we don't love them..."
(Bolivia)

- Participants suggested that in cases where men do not object to contraceptive use, they blame unintended pregnancies on the woman's carelessness or incorrect use of the contraceptive.

"...depends on the method they are using....sometimes they use it wrong..."
(Peru)

"...due to carelessness, because they didn't use a method..."
(Bolivia)

- Focus groups found that when a couple agrees to use contraceptives for the purpose of spacing births and a pregnancy occurs anyway, it was usually because the contraceptive was used incorrectly. Peruvian and Bolivian men said that, since women are the child bearers and know when they can most easily get pregnant, managing these "dangerous days" should be their responsibility.
- Many women participants, especially nonspacers, said negative side effects of contraceptives lead some to discontinue the use of contraceptives and made others fearful of beginning to use them.

"Pills cause excessive headaches and excessive bleeding."
(Delhi)

- Pakistani and Indian women felt that mothers-in-law had a strong influence in deciding what birth spacing mechanism to use. Sometimes the advice was incorrect and they got pregnant, unintentionally.
- In India, participants reported that the mothers-in-law's and other extended family's influence on a couple's birth spacing decisions appeared to diminish as the new couples relationship matures.

Birth spacing practices as viewed by health care providers

Most health care providers in the focus groups said that women of the younger group (15-19 years) and women of low socioeconomic status are typically not active spacers. The providers believed this to be a result of their youth, inexperience and, especially among the recently married, subordination to the men.

Some health care providers in Peru and Bolivia believe that women get pregnant quickly so that the men will be obligated to support the child, and so that they too will be cared for financially.

“They think that the more children they have, the more likely they will be able to keep their partner.” (Peru)

Health care providers in Peru report that birth spacing practices differ in urban, peri-urban and rural localities. In poverty-stricken situations where household overcrowding is common, pregnancies occur more frequently.

“It varies according to geographic regions, in rural areas they have children after a year because of the overcrowding.” (Peru)

Providers in Pakistan said that as the number of children increases, the spacing tends to increase as well: two to three years between the first and second child, three to four years between the second and third child.

E. Couples’ Decision-Making Process Regarding New Pregnancies

The success of optimal birth spacing depends largely on the ability of the couple to discuss, negotiate and make decisions regarding their sexual encounters that may lead to pregnancy.

Focus group findings across countries indicated that many couples seldom discussed or planned pregnancies beforehand. Instead, pregnancies occurred without planning.

“The woman does not have much say in it and if she tries to talk or convince her husband of it (spacing) he fights with her.” (Pakistan)

“There is no decision, it is a natural act.” (Bolivia)

Many participants suggested that couples do not talk about the next pregnancy, that there is no negotiation or pre-planning and, that, on the contrary, males simply impose themselves sexually. There was a cultural feeling among participants that the man often felt he had a “natural” right to demand sex from his wife whenever he felt like it. In male dominated societies, participants noted that the man might oppose his wife’s use of a contraceptive or may unilaterally demand another child, and, on occasion, might carelessly have intercourse during his wife’s “dangerous days” without taking precautions.

“My husband threw the pill from the window and told me, ‘I want children’.”
(Egypt)

Many of the woman participants declared that women risk being treated violently if they refuse to engage in sexual intercourse when the husband demands it, and that the violence may be physical. Participants also suggested that in male-dominated situations, men may exert psychological pressure through verbal threats to make the woman fear being left alone, left unprotected, left without financial support, and left solely responsible for the children already born.

“If she does not follow her husband’s decision, they may end in separation”.
(Egypt)

According to focus group findings, there are few cases in which decisions on birth spacing are not unilateral. These are usually among young, educated, urban couples who have greater exposure to women’s rights and reproductive health information, and are better socialized with the opposite sex in informal settings. This socioeconomic group is most prevalent in Peru and Bolivia.

“We come to an understanding to avoid having more kids.”
(Bolivia)

Very few older men admitted that birth spacing was a shared responsibility. In Bolivia and Peru, both women and men said that contraceptive methods for the purpose of birth spacing were primarily the woman’s concern.

“...I decided...he begged me for another child, but I said no more...”
(Peru)

Some women affirmed that when they had made a decision not to get pregnant, the most frequent way of avoiding pregnancy was to use a contraceptive without telling the man. Otherwise, they simply avoided their husband’s sexual advances with such excuses as having to go visit their mothers, faking illness, or finding some other last minute reason.

Woman participants in the younger age group (15-19 years) who were less experienced, less educated and less empowered, were most unlikely to oppose their husbands’ desire for sexual intercourse, or an explicit request for a child. This group was also less likely to use contraceptives.

“Generally, it is the husband who makes the decision, he decides if he has enough money or not.”
(Peru)

Providers in the five countries reported that women believe the decision to space births is mostly the man’s decision and that men dominate the decision on when a new pregnancy occurs.

“The husband has the most influence. Women seldom do anything without their consent, especially in sexual matters.”

(Pakistan)

The majority of the providers believe that in urban areas, women frequently make decisions on birth spacing. Health care providers felt, however, that in rural areas men were more likely to be the decision makers.

The overall view of providers is that there is not a “culture of conscious dialogue” regarding the timing of pregnancies. This would suggest that the use of contraceptives might be hindered by the lack of dialogue on birth spacing.

F. Family or Community Influence

The focus group results show that family influence plays an important role in birth spacing. In India, Egypt and Pakistan, in particular, mothers-in-law were found to play a key role in when the young bride would become pregnant

Interestingly, when mothers-in-law in these countries were asked what they perceived their influence in the decision making process to be, they said they did not think they played much of a role at all.

“Mothers-in-law are more involved in this decision. Others don’t have as much involvement as mothers-in-law do.”

(Pakistan)

“They [daughters-in-law] may be knowing better...they at least think so.”

(India)

Husbands in focus groups confessed that mothers-in-law sometimes criticize their daughters-in-law if they do not bear children or wait for more than two years between pregnancies.

“We got you here to eat, sleep and reproduce or else I will get my son another wife.”

(Egypt)

Information from the focus groups in India reveals that the influence of the in-laws is greatest in extended families, where family affairs is a decision-making process carried out by the elders or more mature members, such as mothers-in-law. The case is such that, in Panipat (India), the woman has little opportunity to exercise her own individual choice. In Delhi, however, the mother-in-law’s influence on spacing is less because a typical nuclear family structure prevails. The influence on birth spacing of the mother-in-law and the extended family generally appears to diminish as the couple ages and matures. One mother-in-law said,

“They [the couple] are educated; they decide themselves, without my opinion.”

(India)

G. Actual Contraceptive Use

Regardless of who makes the decision to space, many women use some form of contraception. The type of method varies depending on the country, availability and the provider's preference on what method to suggest to clients. In one of the health care provider's words:

"They [other providers] mostly recommend injections and tablets."
(Pakistan)

Bolivian health care providers said the IUD was women's preferred method. In India, women more often mentioned condoms and pills, with the latter being especially preferable to spacers. However, participants still viewed pills as having adverse side effects such as obesity and allergies, and thought the Copper T could be harmful.

"Copper T climbs upwards...causes bleeding." (India)

Women in Peru and Pakistan preferred the injection because of its long-term effect and its inconspicuousness to partners. Injections were also perceived as having fewer side effects and fewer challenges than the IUD. For example, women do not need to schedule for insertions and removals, as with the IUD, nor fear the side effect of bleeding that may necessitate early removal of the IUD.

"I think of all the modern methods, the injection is the best because it doesn't have any side effects on the body."
(Pakistan)

According to participants, each method of contraception is surrounded by misinformation, misinterpretations of side effects and lack of information. Some common reasons that prevent the use of contraceptives are as follows:

- Women forget to take the pill daily, and, when they realize it, they, do not know what to do and do not have health care providers or other knowledgeable people to consult for advice.
- Women do not even try a contraceptive method due to fear of harmful side effects.
- Women receive misinformation about the effects of contraceptives.
- Health care providers do not always properly explain the side effects of a contraceptive or what the woman should do if she experiences them.
- Many women abandon the method when side effects occur.

Focus group findings showed that pregnancy often occurred because couples were using contraceptive methods incorrectly.

"I used the rhythm method and the condom and got pregnant."
(Peru)

Some Indian women said that birth spacing takes place naturally when their menstrual cycle either stops or becomes irregular for one to two years after the birth of the first child, when they are breastfeeding. This belief is shared by some women of the other countries, and they intentionally prolong breastfeeding in order to space their children.

"Menstrual cycle stopped for 1.5 years after earlier delivery."
(India)

Issue of cost

The cost of acquiring a contraceptive, which is frequently beyond the family budget, is also a common barrier for many women. Some husbands do not allow their wives to purchase contraceptives even if they are affordable. This was most frequent in Egypt, India and Pakistan. Many rural women reported that they could not afford transportation to a health facility.

H. Factors/Influences

Cultural differences in individual beliefs influence behaviors. The focus group findings revealed cultural factors that resulted in the following reproductive myths:

The “macho” myth

Some participants felt that men prove their virility by having sex and getting the woman pregnant either in marriage or outside of marriage. This shows that he has the virility to “impregnate” women. If pregnancy does not occur, the man may be viewed as impotent or infertile, his manhood may be questioned and he may lose his “*macho* man” image.

“...men joke....you’re homosexual, effeminate, not a real man if you don’t get her pregnant...”

(Peru)

Because of this myth, women in all five countries expressed the view having sexual intercourse is a man’s right.

“My husband is the main person to decide, I can’t do anything against his wish.”

(India)

“Women don’t have much say in it. Husbands have more authority.”

(Pakistan)

“Sexual satisfaction is the most important thing for men.”

(Bolivia)

The fertility myth

If a man is judged culturally as the truly “virile” man if he can get a woman pregnant, the “fertility” myth judges a woman as truly a woman only if she can conceive.

As reported by women, pressures on the wife for more frequent pregnancies come mainly from husbands, mothers, mothers-in-law and occasionally sisters-in-law. Pressure is in the form of nagging. In Bolivia, the common expression for a woman who does not conceive is a “mule”. Women in Egypt reported that mothers-in-law would frequently refer to these women as “barren land”.

*“Women who do not have many children are like barren land.”
(Egypt)*

Participants said that if a woman does not become pregnant as soon as she is married, she may be viewed with suspicion. Soon there is a strong perception that she is not fertile and not a “true woman”. In the Middle East the ultimate disgrace for the man is that his partner is unable to bear him children. It is interpreted that God is not blessing him, and there is the belief that the wife must be guilty of a previous bad action for which she must pay by being barren.

Myth of the first male son

The male son is of extreme importance in Egypt, Pakistan, India, the “*altiplano*” (highlands) of Bolivia and Sierra of Peru. The first-born son is considered a blessing, both as the guarantee for the father’s name to be passed on to the next generation and as inheritor of the father’s possessions and land.

However, if the first-born is a daughter, the pressure is to have a male son as soon as possible. Participants suggested that a woman will be nagged and then threatened if she does not “produce” the son. Therefore, the pressure is to continually get pregnant until a son is born.

*“...keep trying to have a boy and give birth in quick successions for this...”
(India)*

I. Religious Norms Regarding Birth Spacing

Focus group participants from all countries stated that religion plays a key role in defining reproductive health behaviors. In some countries, reproduction is believed to be in the hands of the Creator and conception is considered to be a God-given gift to men and women that should be respected as sacred. Participants felt that many believed that stopping or altering the process in any way is considered to be a sin.

Most women and men in the five countries said that religious institutions provide incomplete and often contradictory advice on birth spacing and that the general message was “birth space your children, but do not use contraceptives”.

*“They (talk about spacing but without specifying the time. They say children are a blessing from God, but they say you have to take precautions, without mentioning how or for how long.”
(Peru)*

Participants said that Muslim, Catholic and some other Christian religions forbid contraceptives and see them either as a sin or against nature and God's will. Hinduism neither supports nor discourages the practice of birth spacing.

"My family is Evangelist. They say it [contraceptives] is a sin. The Virgin Mary didn't use an IUD, didn't take pills, she didn't do anything like that."

(Bolivia)

Most Pakistani women saw birth spacing as a sin that is not permitted by Islam.

"It's a sin in Islam. It is totally rejected by Islam. Using any method be it operation, injection or any other is like interfering in God's will."

(Pakistan)

J. Birth Spacing Information Provided by Health Services

Health care providers' point of view

The health care providers agreed that there are no policies or procedures about what information should be provided to women seeking advice on birth spacing. Peruvian providers said the Ministry of Health recommended a two-year interval, but that this was not a formalized policy for health institutions.

"There is no written regulation. The National Reproductive Health Guidelines, for example, recommend spacing of more than two years, but it is not a regulation."

(Peru)

The majority of health care providers in all countries specified that two-year birth intervals would be the ideal, but very few recommended 3 or more years.

"Maximum space should be two to three years, not more than that."

(Pakistan)

Nevertheless In India, a few of the health care providers thought that a birth interval of three to four years improves a woman's health.

"Mother will not become anemic if she waits for 3 to 4 years."

(India)

Most health care providers said that the best time to give optimal birth spacing advice is during the prenatal care sessions and postpartum visits. Only one urban site group in Pakistan suggested delivery as the best time to provide women with information and underline the importance of birth spacing.

Peruvian health care providers agreed that younger women should be told to have longer birth intervals because they are less developed both psychologically and physiologically.

In Pakistan the health care providers said that they give women counseling on the optimal length of birth intervals according to the woman's age, current health status and number of children.

Focus groups showed that providers' views on what contraception to suggest to their female clients differed. They tend to suggest methods according to availability and the method(s) they personally endorse.

Providers also reported that rural men tend to believe that having many, closely-spaced children ensures that there will be enough children to fill the roles needed for agricultural aid, household chores and to provide care when the parents become old.

"The more children, the better. The girls help around the house, the mother gives them responsibilities, the boys help in the field. The faster the couple has children, the better." (Peru)

K. Clients Perception of the Quality of the Reproductive Health Service

Client's perceptions of providers, the provider facility (schedules, waiting rooms, bathrooms, etc.) and the quality of care help determine whether or not they will seek out a facility for information about contraceptives.

"When you go for a check-up a week after having your baby, they ask what method you are going to use? Everyone uses injections. I didn't want to because I still hadn't talked to my husband, but they insisted that everyone uses injections, and they gave me one, but they didn't explain. I got one, what choice did I have? But now I use pills."

(Peru)

The perceptions outlined above also affect what kind of birth spacing information a woman asks for at the health facility. In Peru and Bolivia, women 20-30 years of age seeking advice from a facility said they were informed of the advantages of birth spacing, but they were not informed how long the birth spacing interval should be.

"They tell us we should use protection, but not for how long." (Bolivia)

Some visitors to the facility were given incorrect information, such as being told not to come back for a contraceptive method until their menstruation returned.

"I went to the health post to get my injection, but I was three or four days late and the nurse didn't want to give it to me, she said I should return when I got my period and that's when I got pregnant." (Bolivia)

In Peru, some women reported inadequate service in that they requested a contraceptive method, but ended up leaving the health facility without one.

“After I gave birth they did not give me any pills when I asked for them....at the health center they told me ‘after you have your period you can come for your method’ but I did not have a period and I was already pregnant.”
(Peru)

Few men received any contraceptive information, and when they did, it was mostly while their wives were receiving family planning services. In Pakistan, all groups agreed that quality of service, privacy, respectful treatment and attention to client concerns was much better in private clinics than in government ones.

“There is more care in private hospitals and they talk to us very nicely as well. Nurses in government hospitals even beat the patients. They show a lot of disrespect. This doesn’t happen in private hospitals.”
(Pakistan)

“The doctor presents us with two or three methods and says discuss it with your family, but I think this method is suitable for you according to your health.”
(Pakistan)

Nonspacers and Pakistani mothers-in-law said providers often recommend surgical contraception after three to four children. Many Indian women said health workers do not understand birth spacing. Some openly reject the concept.

L. Sources of Information for Contraception and Birth Spacing

Identifying a community’s trusted sources of health information is important for those presenting new ideas and information on the topic of birth spacing. Trusted sources of information are the best disseminators of the new initiative for the three to five year spacing interval due to their influence in the community. In all countries, representatives of the community viewed service providers as educated and trained professionals, who were reliable and trustworthy sources of information.

“...because they are professionals and have studied...”
(Pakistan)

The majority of participants viewed pharmacies as places to buy contraceptives, but not as reliable sources of information about birth spacing.

“They (pharmacies) just sell.”
(Bolivia)

In Pakistan, women felt that it would be appropriate for pharmacies to give out information on birth spacing, but only to men.

“We can’t ask men about it. It’s embarrassing. Maybe they will give information to men if they ask.”
(Pakistan)

Bolivian women did not believe that nurses, traditional birth attendants or pharmacies were good sources of birth spacing information.

“We receive information only from the nurses and we don’t like that.”

(Bolivia)

“We don’t like to get it [the information] from the pharmacy.”

(Bolivia)

Focus group participants generally believed that inserting instructions about birth spacing inside the contraceptive packaging is a good idea.

“It’s a good idea because we would have more complete, direct information.”

(Peru)

Among Peruvian and Bolivian men, the first source of information is their parents. However, when non-family members were cited, physicians, obstetricians and psychologists were mentioned most often. In Bolivia and India, women often mentioned female family members such as mothers and sisters and female in-laws as their source for information and advice about birth spacing.

Many participants also cited the mass media as a source of information.

“...they [radio] discuss different topics like this one...”

(Peru)

“...[Pills] are shown on TV...”

(India)

“...[television] because you can watch and listen, whereas you can only listen to the radio...”

(Peru)

V. SUMMARY OF RESULTS

The following are the most relevant common findings from the focus groups in all five countries. They are important indicators of what should be taken into consideration when designing a plan for introducing optimal birth spacing to communities.

- Most women understand the concept of birth spacing but views differ on the length of time to space.
- All participants agreed that the birth spacing concept should be explained to women in relation to the year when they can get pregnant after the birth of their last child, not in terms of when the next child should be born.
- Even though there is a general acceptance of the three to five year birth spacing interval, especially among women, there is a lack of clarity as to its beneficial effects.

- Reasons why women space their children include:
 - They are older and have already experienced a pregnancy and raising a child.
 - They are more educated about sexuality and reproductive health issues, and they are able to communicate with their husbands.
 - They are more self-confident and assertive.
 - They have more autonomy to make choices and have access to economic resources.
- There is no conscious dialogue between spouses regarding when they want the next pregnancy to occur, it mostly “just happens.” Nor is there real planning regarding when the next pregnancy occurs, so it often occurs when neither member of the couple wants it. Programs should get men and women to discuss the next pregnancy before it occurs, rather than when it has already happened.
- The potential perceived benefits, such as improvements in the woman’s health, the newborn’s health and the family income provide motivating factors which help people adopt new behaviors suggested by the initiative.
- Obstacles that may hinder the adoption of the three to five year birth interval are related to strong cultural pressures, such as:
 - validation of the man’s role by having a son soon after marriage, proving his masculinity by impregnating his partner,
 - having a sense of right over his partner’s sexuality and her response to his sexual needs,
 - disregard for her desire not to have sexual intercourse for fear of getting pregnant or any other reason.
- A woman’s worth is seen in terms of her fertility and motherhood capacity. There is strong pressure for a young woman to become pregnant as soon as she is married.
- Some religions prohibit the use of contraceptives for birth spacing even though these religions (Catholicism, other Christian religions and Islam) do not discourage the concept of birth spacing.
- Health care providers are seen as the most reliable source of information on birth spacing. Media such as the radio and television are held in high esteem and are considered credible sources.
- Pharmacies are not perceived as trustworthy sources of information regarding birth spacing but, instead, as places to buy contraceptives although not to get advice on their use. However, written information on birth spacing inside contraceptive packaging is generally viewed as a good idea.

VI. CONCLUSIONS

Since men and women are already receptive to the concept of a birth spacing interval of three to five years as beneficial for the mother, the child to be born, and the last child born,

the introduction of the new initiative should be easily achievable at facilities where providers counsel women on contraceptives or reproductive health.

However, health care providers recognize that the previous lack of consistency of policies and lack of clarity as to whether the previous two-year interval meant an inter-pregnancy interval (from birth to pregnancy) or an inter-birth interval (from birth to birth) has resulted in some confusion about the optimal birth interval. A redefinition of this previous vague policy as a clear three-year year birth to pregnancy interval will enable it to be disseminated at the facility level.

Adoption of the new norm will require retraining providers to teach that a three-year interval is healthier. Effective communication of this concept demands competent counseling on the sensitive issues involved in birth spacing, family planning and contraceptive use. Such quality counseling requires cultural sensitivity as well as medical and technical expertise.

As indicated by this data, reproductive decisions for woman and couples face barriers that prevent women from adopting optimal birth spacing behaviors even if they wish to. Strong cultural norms prevail, some of which make men, mothers-in-law and other family members behave in ways that are non-supportive of a women's birth spacing desires. For birth spacing counseling to be effective, these norms must be taken into account so that women will be empowered to discuss and negotiate with the rest of the family to avoid having to become pregnant too young and too often. Women who seek this need quality counseling to address fears about contraceptive side effects that may be unfounded and other misconceptions about contraceptives, women's health and fertility. Other problems that women have and that health care providers could address include access to health information, quality of information, privacy, and availability of contraceptives. All of these concerns should be taken into account when introducing optimal birth spacing counseling into the public health sector and Nongovernmental Organization Reproductive Health (RH) programs of the public health sector as well as of the Nongovernmental Organizations (NGO's) which offer RH services.

This summary report of the Focus Group findings in these five countries offers a solid frame of reference of what clients know, believe and encounter as barriers to practicing optimal birth spacing. The design of any OBSI intervention will profit enormously from this rich information. Working within cultural contexts, helping women and men to surmount their perceived barriers is a key component of a successful intervention.



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