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Maternal and Child Survival Program

Family Planning Client Rights Study Report

Assessment of Perspectives and Practices on Rights-Based Family Planning in Baluchistan, Pakistan

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The Maternal and Child Survival Program (MCSP) is a global, $560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. MCSP is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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Abbreviations

CPR	contraceptive prevalence rate
DoH	Department of Health
FGD	focus group discussion
FP	family planning
IDI	in-depth interview
IUD	intrauterine device
LHV	lady health visitor
LHW	lady health worker
mCPR	modern contraceptive prevalence rate
MCSP	Maternal Child and Survival Program
PWD	Population Welfare Department
TFR	total fertility rate
UNFPA	United Nations Population Fund
USAID	US Agency for International Development
WHO	World Health Organization

Executive Summary

Background

In Pakistan, the Maternal and Child Survival Program (MCSP), funded by the US Agency for International Development (USAID), worked in Sindh, Baluchistan, and Punjab provinces with a focus on improving women's and children's health by increasing the availability, accessibility, and utilization of family planning (FP) services. According to the 2017-18 Pakistan Demographic and Health Survey (NIPS and ICF 2019), high fertility, inadequately spaced births, and high unmet need for FP (17%) are associated with poor maternal and child health outcomes. Use of modern contraceptive methods is low (26%), with the method mix skewed toward traditional, short-acting, and permanent methods.

An individual's decision to use a method of FP is considered voluntary if it is based on accurate information and the exercise of free choice, and is not influenced by any constraints, special inducements, element of force or coercion, and manipulation (Hardee et al. 2014). Clients should be provided access to a broad range of FP methods, appropriate counseling, and recommendations based on their contraceptive history, sexual activity, and desired family size, as well as privacy and confidentiality as regular features of high-quality client-provider interaction. Although the terms rights-based, voluntarism, and informed choice have been widely used in routine FP discourse, full realization of these principles remain neglected in practice in Pakistan. With respect to informed choice, only 19% of women report being informed about all three quality-of-service indicators: side effects, what to do in case of side effects, and method mix (NIPS and ICF 2019). Similarly, only 35% of women report being counseled on both method choice and how to use the chosen method (NIPS and ICF 2019).

This report presents findings from a qualitative study conducted in Baluchistan designed to assess clients,' providers', and health manager's knowledge and perception of the right to accurate and comprehensible FP information, as well the right to use a preferred method or not method at all. The secondary objective of the study was to propose a preferred mechanism and medium of receiving the comprehensive and required information

Methodology

This formative study employed qualitative methods, namely focus group discussions (FGDs) and in-depth interviews (IDIs). It was conducted in the districts of Quetta, Pishin, and Naushki in Baluchistan Province in 10 study sites. A mix of high- and low-performing sites were selected based on a health system analysis that looked at FP commodity availability.

Study respondents for IDIs included service providers (10), district health managers (2), female clients (14), and their male partners (4). One FGD was held with community workers (7). FGDs and IDIs were all audio recorded, and field assistants simultaneously took notes. Written informed consent was obtained from all participants before participation. The Johns Hopkins Bloomberg School of Public Health Institutional Review Board in the US approved the study. The field research took place during July and August 2019.

Key Findings

This assessment revealed generally high levels of client satisfaction with FP services received, and key elements of a rights-based approach were realized, according to clients. Women indicated they did not feel coerced by health workers into using FP or limiting future pregnancies nor discriminated against; confidentiality was respected; and they had received information and education that met their needs.

Service providers also generally described counseling on the range of contraceptive options, discussing side effects and supporting women to select a method of their choice. When asked, some providers indicated preferences for specific FP methods due to lack of side effects, confidence in offering the method, or method availability, among other reasons. Additionally, while providers indicated they counseled on method side

effects, they struggled with managing client complaints and expressed that concerns about negative health effects of FP remain a major barrier to contraceptive uptake in these communities.

Across respondent groups, respondents indicated that women's main trusted sources of FP information are friends/neighbors, family members (mothers-in-law and sisters), and health workers. Service providers recognized that social connections (friends, neighbors, family) can pose a challenge, as information (and negative experiences) spreads quickly and broadly within and across these groups. Service providers also recognized the benefits of information flow within and across social groups, as positive experiences are also shared widely and can facilitate enhanced FP uptake. Husbands were reported to play a critical role in contraceptive decision-making, yet respondents recognized a lack of opportunities for men to learn about and discuss FP.

There was general consensus across groups that FP rights are important, including for achieving improvements in broader health and well-being. When asked whether women are aware of their FP rights, service providers showed diversity of opinion, with some expressing that women are aware and others expressing that most are not. Female clients often indicated that women are aware of their FP rights, although there was some diversity of opinion, and male partners generally indicated that women are aware of these rights.

Discussion and Recommendations

The results of this study reveal a number of motivators and barriers with regard to access to voluntary FP services, providing the following opportunities for engagement:

Recommendation 1: Develop a national strategy to raise awareness about clients' FP rights

While clients expressed generally high levels of satisfaction with FP services received, there were wide variations in opinions across providers and managers with regard to the perceived levels of client awareness of their rights. To address this, it is key that the policy environment be supportive of rights-based FP services. Development and implementation of a national strategy on rights-based FP will help support increased awareness of clients' rights at the provider, manager, client, and community levels.

Recommendation 2: Strengthen the enabling environment for frontline health actors

It is important that health facilities not operate in isolation from the adjacent communities they are serving. However, one of the issues coming from the study findings is the challenge of insufficient coverage of lady health workers (LHWs) and male mobilizers, who play a central role in supporting optimal FP practices at the community level. To address gaps, efforts to increase both the FP capacity and coverage of LHWs and male motivators, especially in hard-to-reach areas, is critical.

Recommendation 3: Increase community leadership in health

To promote sustained improvements in the quality of health care, communities must be engaged as active leaders in health solutions rather than as passive "beneficiaries" of health services. While the study highlighted how powerful word of mouth at the community level is in influencing opinions about FP methods, it also showed there are gaps and inaccuracies in information shared between peers/nonhealth professionals and highlighted the need to address key misconceptions around side effects.

To address these gaps and capitalize on the opportunities, community-level interventions should seek to provide more opportunities for community engagement on FP, including creating space for active dialog between communities and health facilities. Interventions should include discussions on client rights,

household decision-making, and capacity-building of community champions, satisfied clients, and religious and community leaders.

Recommendation 4: Develop and integrate strategies to better reach men with FP information and services

This study reported that husbands play a critical role in contraceptive decision-making, yet respondents recognized a lack of opportunities for men to learn about and discuss FP. To address these gaps, specific and purposeful gender activities must be targeted to the entire health system. It is critical to build the capacity of providers to engage men in FP counseling and services, and support them to work with their partners to decide on family size. This includes supporting implementation of the updated National Action Plan for FP, which includes an enhanced role for male mobilizers.

Recommendation 5: Continue to build provider skills and confidence in counseling/provision of the full range of contraceptive options and addressing client complaints of side effects

An onsite clinical capacity-building approach, coupled with supportive supervision, is recommended as evidence increasingly suggests that learning within the workplace in short segments with frequent practice is more effective at impacting performance in the long term and supports improvements in health worker capacity to meet quality of care standards in the short term. While providers discussed counseling clients on a range of FP options and their side effects, many requested additional training, and not all were competent in the full range of methods or managing side effects for certain methods.

Health service providers should receive additional training and support to improve their counseling skills and service delivery practices surrounding FP. This will require incorporating opportunities for values clarification to address perceptions hindering high-quality service provision.

Recommendation 6: Assess the role of provider FP method preferences in service delivery

When asked about preferred contraceptive methods, many providers did indicate that they had specific methods that they prefer to recommend and some that they did not prefer. These preferred methods varied by provider and were based on ease of use by the client, availability at the health facility, acceptability to male partners, and community preferences. These preferences may affect the methods providers emphasize during client counseling.

To address this, it is key to focus on building provider skills and confidence in FP counseling and method provision on the full range of contraceptive options. Further investigation is required on the role of provider method preferences. Based on findings, barriers should be addressed that may be contributing to these preferences (e.g., lack of skills, contraceptive stock-outs). Provider behavior toward clients is influenced by many factors, including values, social and gender norms, supervision, skills, knowledge, and structural context. Thus, it is important to address not just external motivation and provider skill factors, but also address internal or intrinsic motivating factors.

Recommendation 7: Address Contraceptive Stock-Outs

There were variations in provider responses regarding contraceptive stock-outs, with some indicating stock-outs had not posed a problem and others indicating stock-outs were a critical barrier to FP uptake at their facility. Addressing stock-outs across facilities is a key component to ensuring access to high-quality, rights-based FP information and services.

Background

Ensuring Family Planning Is a Voluntary, Informed Decision

Access to voluntary family planning (FP) is a basic human right, yet clients are sometimes unable to use their desired contraceptive method due to barriers imposed by the health system and their social network. The right to informed choice was asserted as a fundamental principal of high-quality FP services at the 1994 International Conference on Population and Development in Cairo, where it was declared that reproductive rights:

> *"…rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so, and the right to attain the highest standards of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in the human rights document."–UNFPA 1995*

Coercing clients to use a specific method of FP, denying method use altogether, or preventing them from obtaining a method of their choice constitutes a gross violation of reproductive rights. Some have argued that governments have an obligation to not only offer access to contraception but also maintain a minimum level of quality to uphold their citizens' rights under the International Conference on Population and Development platform of Action (RamaRao and Mohanam 2003, Cottingham et al. 2012). Thus, factors compromising the quality of services include stock-outs or inconsistent provision of a wide range of safe and effective methods, inadequate information and counseling on methods available in the system, lack of client confidentiality, deficiencies in infrastructure and equipment, inadequate number of skilled providers, provider bias and insensitivity, distance to health facility, and affordability of FP services. Policy-level violations of voluntary FP rights include enforcement of policies that limit the number of births allowed to couples, enforcement of mandatory contraceptive use policies, contraceptive use measured as a target or performance indicator, and the use of incentives and disincentives (Hardee et al. 2014).

An individual's decision to use a method of FP is considered voluntary if it is based on accurate information and the exercise of free choice, and is not influenced by any constraints, special inducements, element of force or coercion, and manipulation (Hardee et al. 2014). Clients should be provided access to a broad range of FP methods, appropriate counseling, and recommendations based on their contraceptive history, sexual activity, and desired family size, as well as privacy and confidentiality as regular features of high-quality client-provider interaction.

The growing attention to high-quality, rights-based FP has prompted a surge in client-centered research and programming in a variety of settings. Findings suggest that women who have access to complete information, a full range of method choices, and high standards of care are more likely to adopt a contraceptive method, continue use, and be satisfied with it. Further evidence of voluntarism and quality is proffered when women recommend their method or a particular facility or provider to others in their social network. Moreover, countries with a broader method mix have a higher contraceptive prevalence (Mbizvo and Phillips 2014). In India, the intrauterine device (IUD) continuation rate was higher among women who had been counseled about female anatomy and reproductive organs, the process of IUD insertion, and common side effects associated with method use (RamaRao and Mohanam 2003). Similarly, method adoption and continuation were high among Bangladeshi women who received moderate to high standards of care from female field workers, where quality of care was measured by the frequency of home visits conducted by field workers, the amount of time they spent with clients, and the number of contraceptive methods discussed (Koenig et al. 1997). A study from Nigeria found that among nurses certified to provide FP services, those who received additional training in interpersonal and communication skills demonstrated an improvement in quality of service provision (RamaRao and Mohanam 2003). With respect to health facility infrastructure, shorter waiting times, fewer stock-outs of contraceptive methods and supplies, broad method mix, assurance of client confidentiality, and presence of trained providers were associated with higher client satisfaction in Kenya (Agha and Do 2009, Hutchinson et al. 2011).

Based on the fundamental principles of autonomy, beneficence, and equity, the conceptual framework developed by Hardee and colleagues (2014) offers a human rights-based and client-centered approach for the design, implementation, and evaluation of voluntary FP programs across the policy, service, community, and individual levels. Similarly, the World Health Organization (WHO) tiered-effectiveness counseling model enables providers and clients to comprehensively evaluate methods based on their relative effectiveness, consequently reducing the likelihood of misinformed choice (Stanback et al. 2015). From a donor perspective, projects funded by the US Agency for International Development (USAID) are required to comply with several US legislative and statutory policy requirements relating to informed choice and voluntarism in the provision of FP services.

The FP Landscape in Pakistan

Although Pakistan is among the first countries in Asia to launch national-level FP programs, its demographic transition is delayed due to the slow rate of fertility decline (Hardee and Leahy 2008). According to the 2017-18 Demographic and Health Survey analysis, Pakistan has a total fertility rate (TFR) of 3.6 births per woman and a relatively stagnant modern contraceptive prevalence rate (mCPR) of 26% among married women. Both TFR and mCPR are inversely associated with level of education, rural residence, and wealth quintiles, whereas there is substantial variation by region, with Baluchistan Province ranking among the highest for TFR (4.0) and lowest for mCPR (14%) (NIPS and ICF 2019). A recent study in Punjab by Azmat et al. (2015) found that women's age, husbands' education, spousal communication, location of last delivery, and favorable attitude toward contraception are other key factors associated with current contraceptive use.

The method mix in Pakistan is skewed toward traditional, short-acting, and permanent methods, especially male condoms and female sterilization. While nearly 44% of all modern contraceptive users obtain their methods from public-sector facilities, the private sector provides contraception to 43% of users. Although WHO recommends an interpregnancy interval of at least 24 months before attempting the next pregnancy, 37% of births in Pakistan occur within 24 months of the preceding birth, suggesting a severe unmet need for postpartum women (Moore et al. 2015). Men are significantly more likely than women to want another child within the next 2 years, and the desire to limit childbearing is noticeably strong only after the couple's fourth child (NIPS and ICF 2019). In their role as heads of households, husbands are also reported to have a strong influence on women's health-seeking and FP decisions (Azmat et al. 2015, Azmat et al. 2012). Other notable barriers to contraceptive uptake include social pressure to prove fertility, fear of side effects, lack of access to FP services, negative provider attitudes, restrictions on women's mobility, and affordability of contraceptive methods (Azmat et al. 2012).

The Government of Pakistan is committed to achieve universal access to reproductive health and has pledged to increase the contraceptive prevalence rate to 50% by 2020 by ensuring optimal private- and public-sector engagement, offer greater contraceptive choices by improving the method mix and, expand the program to involve men and gatekeepers (FP2020 2018). In Pakistan, FP programs are overseen by the provincial government after the devolution of the federally controlled Health and Population Welfare Program to the provinces in the wake of the 18th Constitutional Amendment (FP2020 2016). Built on the principles of equity, efficiency, voluntarism, and sustainability, the population policy emphasizes the adoption of small family norms through voluntary FP (Government of the Punjab PWD 2017, Government of Sindh PWD 2016).

Although the terms rights-based, voluntarism, and informed choice have been widely used in routine FP discourse, full realization of these principles remain neglected in practice in Pakistan. With respect to informed choice, only 19% of women report being informed about all three quality-of-service indicators: side effects, what to do in case of side effects, and method mix (NIPS and ICF 2019). Similarly, only 35% of women report being counseled on both method choice and how to use the chosen method (NIPS and ICF 2019). According to a 2016 landscape analysis conducted by the Population Council, only 10% of private facilities in urban areas (and even fewer in rural areas) provide a combination of condoms, oral contraceptive pills, injectables, and emergency contraception (Population Council 2016). Other barriers to service provision include stock-outs, low motivation among providers due to perceived lack of demand, low client acceptance

of male providers, and inadequate training to provide the method or manage potential side effects (Population Council 2016). These findings are particularly relevant to the present study, which was designed to qualitatively assess clients' and providers' knowledge and perception of the right to accurate and comprehensible FP information, as well the right to use a preferred method or not method at all.

MSCP's FP Intervention in Pakistan

In Pakistan, the USAID-funded Maternal and Child Survival Program (MCSP) worked in Sindh, Baluchistan, and Punjab provinces, with a focus on improving women's and children's health by increasing the availability, accessibility, and utilization of FP services. Based on concerns about susceptibility to violation of voluntary FP rights, it was deemed necessary to devise a surveillance mechanism at the provincial and district levels to ensure that client-centered, high-quality FP services are provided to eligible clients. Working with provincial Departments of Health (DoHs), the Population Welfare Department (PWD), and the People's Primary Healthcare Initiative (in Baluchistan only), MCSP supported innovative approaches to strengthen client-centered, high-quality FP services and to promulgate principles of voluntarism and informed choice in FP service provision. Working collaboratively with USAID, the DoH, and the PWD, and through iterative field learning, MCSP developed a dynamic compliance monitoring model consisting of four steps: planning, workforce development, monitoring, and action planning.

During the course of supporting provincial and district managers in implementing strategies to promote client-centered FP services consistent with the principles of voluntarism and informed choice, MCSP staff made the following observations: while providers complied with the principles, the conversations revealed gaps in their understanding of client rights to comprehensive and comprehensible information, and clients demonstrated lack of awareness of their rights with respect to quality of care and access to FP services. In the hopes that better understanding the issues would equip the health and population welfare systems to correct this situation, MCSP proposed a qualitative study in Baluchistan. Located in southwestern Pakistan, Baluchistan is the largest of four provinces. With a TFR of 4.0 and mCPR of only 14%, Baluchistan has the highest unmet need for FP (22%) in the country (NIPS and ICF 2019).

Purpose of the Study

The primary objective of this qualitative assessment was to understand female and male clients', service providers', and health managers' perspectives and understanding of clients' rights to comprehensive information and choice of preferred FP services. The secondary objective of the study was to propose a preferred mechanism and medium of receiving the comprehensive and required information.

Specific research questions were to describe:

- Perspectives on clients' rights to have access to accurate and comprehensible information and to choose an FP method
- Perspectives on providers' responsibilities for providing FP counseling and services
- Experiences of FP information/services received by those residing in the study area and how those experiences might align with expectations regarding quality of care
- Possible channels and mechanisms to provide information to clients about their rights to have access to accurate and comprehensible information and to choose their FP method

Methods

Study Overview

The study design was qualitative and conducted in the districts of Quetta, Pishin, and Naushki in Baluchistan Province in 10 study sites. A mix of high- and low-performing sites were selected based off a health system analysis that looked at FP commodity availability.

Data Collection

The assessment included semistructured qualitative interviews with various stakeholders of the health system, as well as female clients and male partners. A consultant led the in-depth interviews (IDIs) and focus group discussions (FGDs) during July–August 2019. MCSP staff with experience in qualitative methods provided technical oversight and data collection support. Study team members were oriented on ethical considerations of data collection to ensure voluntary participation in the assessment and strict confidentiality of respondents. FGDs and IDIs were audio recorded, and field assistants simultaneously took notes. Written informed consent was obtained from all participants before participation. The in-country study team transcribed and translated the data.

1. **IDIs with service providers:** IDIs were conducted with service providers in intervention districts of Baluchistan Province (Quetta, Naushki, and Pishin). The study team generated a list of all primary-, secondary-, and tertiary-level facilities with and without frequent stock-outs from both departments (DoH and PWD). It then categorized these facilities based on the availability of FP supplies during the past 3 months into those with frequent stock-outs or those with a steady supply. In consultation with government stakeholders, five facilities were purposively selected from each of the two categories. Similarly, one FP service provider was interviewed from each of the 10 selected facilities.
2. **IDIs with district health managers:** Two IDIs were conducted with district health managers to understand their perspective on clients' rights to accurate and comprehensible information and a method of their choice, providers' responsibilities, and possible mechanisms to ensure clients' rights in service delivery.
3. **IDIs with female clients and their male partners:** Fourteen women were interviewed using a semistructured questionnaire. Four male partners were also interviewed separately by male interviewers using a semistructured questionnaire. Female clients were categorized based on their experience with FP

methods: women who have never used contraception, women currently using a method, and ever users of contraception who have discontinued use. Since lady health workers (LHWs) have access to women and their contraceptive history, female clients belonging to each of the three categories were invited to participate in the study through LHWs. Male clients were also identified with the support of lady health visitors (LHVs).

4. **FGD with community workers:** Seven LHWs were invited to participate in an FGD. An FGD guide was used to explore their understanding of clients' rights and their perspectives on how to ensure clients' rights to access FP information and to choose a method during community outreach services.

Table 1. Number of Participants by Respondent Group

Respondent Group	Number of Participants
In-depth Interviews	
Service Providers (Female)	10
District Health Managers (Male)	2
Female Clients	14
Male Partners of Female Clients	4
Focus Group Discussion	
Lady Health Workers	7
Total Sample	**37**

Data Analysis

All interviews were conducted in Urdu, audio recorded, transcribed verbatim, and translated into English for data analysis. An inductive thematic approach (Braun and Clarke 2006) was used to develop a codebook to guide the analysis. The study team identified emergent themes, including perspectives on client rights, barriers to rights-based FP, facilitators for rights-based FP, FP service delivery practices, and recommendations to strengthen rights-based FP. Transcripts were analyzed using NVivo software (version 11).

Ethical Considerations

A nonhuman subjects research determination request was approved by the Johns Hopkins Bloomberg School of Public Health Institutional Review Board. A written informed consent was obtained from all respondents before their participation in the interviews.

Results

Client Perspectives (Female Clients and Male Partners)

Female respondents generally had a large number of children (mean 6, range 2–13), were often socially isolated, and had husbands who generally worked as day laborer. Several had children or husbands with disabilities.

Perceived Benefits of FP Use

Female clients, including past and current FP users and nonusers, widely recognized the benefits of pregnancy spacing and FP use. The main motivations for using FP cited included mothers' ill health, economic constraints, and desire to devote time and resources to existing children. As noted by one past FP user:

> "*I have been ill and have severe health issues, hence I cannot afford to bring more kids. My husband also does not have any permanent job, so financially we are also very weak and cannot bear the expenses of our children.*" –Past FP user

Among the male partners, three of four were generally supportive of FP use. The remaining husband expressed that pregnancy spacing was acceptable only if the health of the mother is compromised:

> *"If the female's health is not well and she is weak, then she can have a gap for 2 or 3 years. If her health is fine, it is wrong to stop having children. Our religious leaders also say that if the female's health is not good and she is weak, she can have spacing up to 3 years, but if she gets well, then she should not stop children."*

Barriers to FP Use

The main barrier to FP uptake and continuation was concerns about negative health effects. Respondents noted a wide variety of concerns related to use of different FP methods, grounded either in their own past experiences using the method or from hearing about experiences of neighbors and family members. For example:

> *"I heard about [IUDs] from one of my friends who is using this, and she said it increased her belly. My sister-in-law used Depo injection, and she had excessive bleeding."* –Never user of FP

> *"A friend of mine used those injections to have some space, and it's been 17 years she is trying hard to have kids, but due to those injections, she was never able to conceive again, and that's why mostly women are afraid of choosing injections. There are many side effects associated to FP methods."* –Past FP User

Additional barriers cited included partner and family opposition and lack of knowledge of contraceptive options. One female client who is currently pregnant noted the following:

> *"My husband is the only son of his parents, and my mother-in-law wants that his son should have many children to work in the fields and home. In the beginning, my husband told me to do what his mother said, but now he is fed up, and he told me to have operation [tubal ligation]. I have tried myself to abort this child, but I could not succeed. Now after the birth of this child, I will have operation."* –Never user of FP

A current FP user also mentioned:

> *"At the last stage when women have more than 10 children and they became anemic or near to death, then their husband allow them to have FP. And now men allowed their wives to have FP due to the fact that in our area, many women have died during deliveries, and we have witnessed many deaths since last 2 years, so men become afraid—that's why they are allowing their wives for FP. My husband also gave me permission for an operation due to this fact."* –Current FP user

Female clients reported high levels of method switching, with many respondents having tried several different FP methods. Switching was usually due to concerns about negative health effects of the method used. These finding are consistent with the 2017-18 Pakistan Demographic and Health Survey that found a first-year contraceptive discontinuation rate (all reasons) of 30.2%.

Information Sources and Decision-Making

Female clients were asked where they obtained information about FP. Key sources of information include the health facility (either from them receiving information directly, or through friends or family who had visited the health facility), female friends and neighbors (including those who had used FP methods themselves), mothers- and sisters-in-law, and LHWs. Sometimes this information is passed from one source to another through an information-sharing chain. For example:

> *"We get this information from elders outside our family, like my mother-in-law asked someone outside our family, then she told my sister-in-law, and then she told me."* –Current FP user

Male partners described gaps in sources of FP information for men:

> *"There is no source of information on FP for men; even we do not discuss it between friends."*

> *"Every man should be given information about FP. Some people work in coal mines and some of them are doing agriculture, so these people do not have any information about FP. If a woman is coming to health facility, it is also her responsibility to provide that information to her husband as well which she received from the health facility."*

Most female respondents were aware of several FP methods. Male partners (except for one respondent who was more knowledgeable) indicated that they were aware of condoms but no other method. For example, one male partner said, "I use condoms, and this is the only method I know."

With regard to FP decision-making, female clients generally reported that they and their husbands made the decision together, but the final decision is up to the husband. All four male partners indicated that FP decisions are made together with their partners. Mothers-in-law were also sometimes reported to play an important role in influencing decisions about FP use. As noted previously, women also consulted with friends and neighbors, sisters-in-law, service providers, and LHWs for advice about FP.

Service Experiences

Female clients generally expressed high levels of satisfaction with FP services. They indicated that service providers had listened to them, explained information carefully, and interacted respectfully.

> *"They give us proper time and listen to us carefully, and we are satisfied with the service they provide."* --Past FP User

Female clients generally mentioned that when they sought FP services, the provider discussed a variety of FP options and that the clients themselves ultimately (often with guidance from their husband) made the decisions about which method to select. Clients widely expressed that they felt they had been engaged in discussion and decision-making process with regard to method choice, and that they had received valuable advice from the provider. Some female clients also mentioned that the provider had discussed possible side effects with them. For example:

> *"I asked the provider that I want to have a gap between children and she listened me quite politely and told me the methods of spacing including their side effects and asked me to decide the method of my choice."* –Past FP user

Women did not report feeling pressured by service providers to use an FP method. For example, as noted by two female clients:

"I did not have any pressure from any one. I was unaware of FP because my social interaction was very limited; otherwise, I would have done it before." –Past FP user

"I don't have any pressure from my family, husband, or provider, but I cannot tell you about the others." –Current FP user

Women also indicated that they felt that service providers protected their confidentiality and expressed trust in providers. No respondents expressed concerns about confidentiality. One past FP user noted:

"They keep it confidential. A few women come here secretly without telling at their homes, but all the women have trust in them." –Past FP user

However, it should be noted that several female clients indicated that while they expressed interest in using FP, they were told that they were ineligible or needed to return at a different time due to their health status or to wait for menses to return.

Among the male partners, three of the four indicated they had not sought FP services themselves, so they did not have substantial insights into service experiences and quality. The fourth male partner had visited the health facility for condoms and reported that services were easy to access and confidentiality was maintained.

Client Rights

Clients were asked to share their perspectives on clients' rights to access accurate and comprehensible FP information, and to opt for a method of their choice. Several respondents indicated they were aware of their right to FP. One woman said that her awareness of this right is what motivated her to seek FP services, and another said that understanding her rights gave her the courage to discuss FP with her husband. On the other hand, one respondent indicated she believed that women in her area were not aware about their right to FP services. Male partners generally expressed that women are aware of their rights to FP use. One male partner noted:

"90% of the women are aware of their right of access to information on FP. 10% are not aware of their rights."

Client Recommendations

When asked, most clients generally did not offer specific recommendations for improvements to FP services. However, one female respondent did mention the need to train junior staff to be more respectful to clients. Another recommended that there should be communication materials with visual pictorials included in FP counseling. Two other female respondents mentioned the need for greater community engagement and education on FP methods to address negative information and build buy-in among men.

Men also highlighted the need for more efforts to reach men regarding FP. For example:

"There should be some programs/sessions/seminars on the awareness of men on FP. We can also talk on TV and media about this, and nowadays social media is also very effective tool for awareness."

"We can give information in schools and similarly as polio workers go door to door, and there should be men in them who can give information to the men on FP. Center can also be used as source of information for men if they designate one day a week for men, like Sunday."

Health Worker and Program Manager Perspectives (LHWs, Facility Providers, Managers)

FP Service Delivery Barriers

Providers indicate that friends and neighbors, family members, and health workers were the primary sources of FP for women in their catchments, as described below:

"They get this information from their neighborhood and their mothers-in-law. They share this information with each other." "They might get this information from their family, like from their mothers-in-law and sisters-in-law, and the reason is that people are living in combined family."

The main barriers to FP service provision cited by service providers include client misconceptions and rumors about FP methods, incorrect method use by clients, partner and family opposition to FP use, stock-outs, and lack of provider training and confidence in providing specific methods.

Many providers spoke about how powerful word of mouth at community level is in influencing opinions about FP methods. Oftentimes, there are gaps and inaccuracies in information shared between peers and nonhealth professionals, and information may be distorted as it flows from person to person. As noted by these two providers:

"We find it difficult to remove the myths they get from the society. If a woman has experienced any side effect, it is not important the other woman will experience the same, but they think that [if] she experienced [that], I will experience that too. If a woman had an implant suppose and she had any side effect, she would start frightening others that she is gaining weight and having spotting."

"Similarly, if someone had bad experience … the negative information spreads like a fire in all the women, and they do not come to the center."

Communication through social networks was also seen to play a positive role when satisfied users share their experiences with others in the community.

Providers also discussed that challenges with correct use also affect effectiveness of and trust in FP methods. This is especially the case for contraceptive pills, with which providers report women having challenges taking on a daily basis. The barrier of partner and family opposition prevents some women from starting an FP method and leads others to seek out FP methods clandestinely. For example, two providers noted:

"Many people are against FP, and they have their Islamic point of view on it. Many females come here but their husbands are not willing and try to convince the women and they also want FP, but their husbands are not willing to allow them for FP. They use pills without telling their husbands and they also use condoms."

"We educate our clients about the FP methods, but their husbands are not willing to do that. They do not use condoms, so women come here secretly for injections without telling anyone. Women are willing for FP, but there is not acceptance in their men, and they say that this is like inviting Allah's anger."

There were variations in provider responses regarding contraceptive stock-outs, with some indicating stock-outs had not posed a problem and others indicating stock-outs were a critical barrier to FP uptake at their facility, as evidenced by the following quote:

"The biggest challenge we had was with unavailability of contraceptive for two years. We only had IUD, and we were only able to deal with IUD clients. That was a big gap that we were sitting for the provision of FP services, but we did not have commodities related to that."

Some providers mentioned that they lack up-to-date FP training and indicated that they are either unable to or lack confidence in providing certain methods to women, compromising the comprehensiveness of services they are able to provide and requiring offsite referral for women to obtain the method of their choice. Providers also noted in some cases that they do not feel equipped to address women's concerns about side effects associated with certain methods. As noted by a service provider:

"We get complaints from some of clients that due to the use of condom, their (women) belly is getting fatty. We have not received any training so we do not know why it is so. We need training on these things. If we recommend Famila injection [Zafa brand] to the clients and they come back that they are experiencing heavy bleeding, we do not have any answer to it."

Managers also cited the challenge of insufficient coverage of LHVs and male mobilizers. According to one manager, there are only four male mobilizers in Quetta, which limits efforts to reach men. According to the other manager:

"There is another issue that women do not share FP related things with any male health provider and number of LHVs is very limited and there are total of 6-7 LHVs we have. If you see in 31 BHUs, one of tehsil [subdistrict] does not have any LHV. LHVs are not willing to go far-flung area which are 50-100 km away from here and there is no other facilities available."

FP Service Delivery Facilitators

Service providers described strategies they use to address barriers to uptake and facilitate use. These included focusing on providing high-quality counseling and rapport building, and incorporating discussion of alignment with religious values. For example, as noted by one service provider:

"Women say that their husbands and mothers-in-law say that stopping child is sin. We give them reference from Holy Quran that a mother should feed her child up to 2 years, and most the women conceive another child while her first child is only 6 months."

One provider described using innovative counseling approaches to help address women's misconceptions regarding certain methods. As noted by one provider:

"In the beginning, people were reluctant due to lack of awareness and knowledge. Sometimes some uneducated clients start believing in rumors like [IUD] clients say that they heard from someone that it is harmful for heart. I satisfy them with demonstration by using balloon and considering it uterus and putting [IUD] inside it and explain them the uterus is closed like this, how the [IUD] would goes toward the heart. So I would say that misconceptions are common here."

Several providers also mentioned the power of positive client experiences for motivating others to use FP. For example:

"They get this information easily and they have social interaction. If I convince a client here at facility, she would talk to others and I will get two to three clients like this."

FP Counseling Techniques

Providers discussed counseling clients on a range of FP options and their side effects. They reinforced the importance of building rapport with the client and dedicating sufficient time to address client concerns. For example:

"I give the full information about the FP methods including their merits and demerits. So that they can easily decide what method they should go for. The key factor is that how you give them the knowledge and when you give them full information, they happily adopt the FP method of their choice based on their understanding and knowledge about the method."

"I give them complete information including the side effects of different methods and I tell them not to worry that these thing are normal. When the clients use any method and experience all that which was told by the doctor, they give positive information about FP to others. Clients get engaged with me and some of the clients came to me which were taking treatment from somewhere else and experienced the side effects and counseled them and when they got to know that it is normal and everyone experience this, they were satisfied and they decided to continue it."

"I give proper time to each patient, this is my old habit once your rapport is not built with the patient, and the patient will not take your treatment. Mostly doctors do not encourage this; they say to keep a distance. I become very friendly with my patients so that they tell me everything and my advice also affects them. I do not care about the time that I am getting late from home. I give proper time to the patient."

Providers did mention tailoring counseling and recommended FP methods based on the client's health status, postpartum status, and number of births.

While some providers freely provided contraceptives to women based on their choice, several providers also mentioned the importance of involvement of the husband in the decision to use a contraceptive method. For example:

"It should be with the mutual understanding of husband and wife otherwise they will have problems afterward."

Provider Preferences

When asked about preferred contraceptive methods, many providers did indicate that they had specific methods that they prefer to recommend and some that they did not prefer. These preferred methods varied by provider and were based on ease of use by the client, availability at the health facility, acceptability to male partners, and community preferences, as illustrated in the following quotes:

"I am less likely to prefer injection because clients often face menstrual irregularities. I am afraid that they would spread negative information about that."

"We received a 10-days training on FP and we were told about the side effects of the different methods and their solution so we also tell our clients about that but we prefer them to use condoms to avoid any inconvenience."

"I do not mostly recommend Jadelle … I saw many patients coming back for the removal of Jadelle. They faced continues bleeding after insertion of Jadelle. … There are many side effects of Jadelle which are intolerable and we cannot control them. Injections also have side effects but that can be controlled by the medicines."

This last quote suggests a lack of provider awareness or reflection about the similarity in the active agents in implants and injectables, and helplessness to manage complaints about side effects. These preferences may affect the methods emphasized by providers during client counseling.

Client Rights

Service providers acknowledge the importance of clients' FP rights. However, there were wide variations across providers in reported levels of client awareness of their rights. Providers discussed the importance of strengthening counseling on client rights and increasing communication on this within community engagement platforms and media. Providers noted:

"It depends on the environment of their family, some of the families do not allow their women to go outside and their husbands are very strict. Due to this their social interaction becomes very limited so due to this reason their awareness level is low."

"No, most of the clients are not aware of [their rights]. They think that they can only opt for FP methods only when their mothers-in-law or their husbands tell them to do so. I tell them that it is your right to have baby or not. According to them the decision-makers are their mothers-in-law or husbands who decide when to have kids and how many. When I ask them

about their opinion, they say no they do not want more. There are many cases like that. They come and say that they heard about it from their sisters-in-law and discussed it with their husbands and mothers-in-law and they should have birth spacing. After doing all and getting permission from her husband they visit the facility. There are few good husbands as well and when their wives ask them to have child spacing, husbands tell them yes they are weak and they should have the spacing."

Strategies to Improve FP Uptake and Service Quality

Providers were asked what would be needed to improve FP services at their health facilities. Respondents mentioned needing additional FP training, including on provision of implants and IUDs and counseling techniques. They also mentioned the need for more efforts to reach men, mothers-in-law, and religious leaders to improve their support for FP, as well as more focus on household visits and provision of FP information and services at outreach camps.

Manager Perspectives

The team interviewed two health managers regarding their supervision and monitoring processes, barriers to FP uptake and quality service provision, their perceptions around client rights, and recommendations. The managers described monitoring FP service provision and service use through using monitoring checklists, reviewing monthly service data reports, visiting facilities (sometimes during surprise visits), and convening monthly meetings with various cadres to provide feedback. Key barriers to FP uptake cited by the managers included unavailability of FP commodities, difficulty in reaching populations in "far-flung" locations, religious and gender barriers in receiving services from a male provider, and the small number of male mobilizers.

With regard to clients' rights, one manager felt that awareness of client rights was high, whereas the other felt that awareness was generally low. Beyond awareness, both managers expressed that clients are often not empowered to discuss FP:

"They have awareness but I think they are shy to talk about FP. Cultural constraint and social taboos are there. A boy cannot discuss with his father, on the other hand girls can discuss with mother or sister and she can get a little guidance. There is a need of working on the awareness of men. Sometimes men ask me that their wives were asking about FP and what is that. It means men need to be educated on contraceptives. Women can even argue that they are not a production machine and they have to take care of other domestic chores as well."

"These issues are being highlighted that women are not accepting due to their husbands/males. Women are not empowered enough for informed choices in FP services."

The manager also mentioned the importance of maintaining client privacy when seeking FP services. However, not all managers fully embrace rights concepts. One manager mentioned he believed FP use should be incentivized:

"Driving licenses and other facilities form government should be given to those people who follow FP policy. There should be some sort of incentives for people in FP policy."

Both managers discussed how, in order to realize clients' rights, the focus needs to go beyond developing policies to ensure the policies are implemented in practice.

"Developing policies and laws is one thing and implementation of those laws and policies is another thing. There are many laws on different things but they are not being implemented."

Additionally, managers recommended additional investments in raising community awareness about client rights, male engagement, and provider behavior change.

"The main focus should be on behavioral change. I think your behavior being a provider plays an important role in FP. Providers' behavior, politeness, rapport building all are important for a provider."

Discussion

This assessment revealed generally high levels of client satisfaction with FP services received, and key elements of a rights-based approach were realized, according to clients. Women indicated they did not feel coerced by health workers into using FP or limiting future pregnancies nor discriminated against, confidentiality was respected, and they had received information and education that met their needs. Some courtesy bias cannot be ruled out, but the client reports are reassuring.

Service providers also generally described counseling on the range of contraceptive options, discussing side effects and supporting women to select a method of their choice. When asked, some providers indicated preferences for specific FP methods due to lack of side effects, confidence in offering the method, or method availability, among other reasons. While this assessment did not allow us to delve into how provider preferences affect service delivery in practice, this is an important area that should be explored and addressed through future programming. Additionally, while providers indicated they counseled on method side effects, they struggled with managing client complaints and expressed that concerns about negative health effects of FP remain a major barrier to contraceptive uptake in these communities. It should also be noted that client reports of discontinuation because of troublesome side effects is not unique to this study population. The Pakistan Demographic and Health Survey has noted a first-year contraception discontinuation rate of 30.2%. Thus, while providers in this study clearly know and report that they discuss side effects with clients, there is room to improve the availability of information in the general population. Some clients may be obtaining their methods from private-sector outlets, which may not offer counseling.

Across respondent groups, respondents indicated that women's main trusted sources of FP information are friends/neighbors, family members (mothers-in-law and sisters), and health workers. Service providers recognized that social connections (friends, neighbors, family) can pose a challenge, as information (and negative experiences) spreads quickly and broadly within and across these groups. Service providers also recognized the benefits of information flow within and across social groups, as positive experiences are also shared widely and can facilitate enhanced FP uptake.

Husbands were reported to play a critical role in contraceptive decision-making, yet respondents recognized a lack of opportunities for men to learn about and discuss FP. While the providers interviewed mentioned the important role of husbands, including the importance of engaging them in decision-making regarding FP, they only reported suggesting women discuss it with their husbands at home, no providers reported inviting male partners to come for FP services (it should be noted that all the service providers interviewed were female, and additional cultural barriers impact these male-female relationship dynamics).

There was consensus across groups that FP rights are important, including for achieving improvements in broader health and well-being. When asked whether women are aware of their FP rights, service providers showed diversity of opinion, with some expressing that women are aware and others expressing that most are not. Female clients often indicated that women are aware of their FP rights, although there was some diversity of opinion, and male partners generally indicated that women are aware of these rights.

Programming Opportunities and Recommendations

Programs that adopt a rights-based approach in delivering FP aim to fulfill the rights of all individuals to voluntarily choose whether, when, and how many children to have; to act on those choices through high-quality sexual and reproductive health services, information, and education; and to access those services free from discrimination, coercion, and violence.[1] The growing attention to high-quality and rights-based FP in Pakistan prompted a recent surge in client-centered research and programming, and results from this study contribute to that body of evidence. Study results are important to inform Pakistan's DoH and PWD, the donor community, and implementers across the country to plan and implement high-quality, rights-based FP

[1] http://www.familyplanning2020.org/search?keys=Rights-Based+Family+Planning

services. While the government can develop and implement the recommended strategies and plans through their own resources, additional technical support may be required.

As described in this report, the results of this study reveal a number of motivators and barriers with regard to access to voluntary FP services, providing the following opportunities for engagement:

Recommendation 1: Develop a national strategy to raise awareness about clients' FP rights

While clients expressed generally high levels of satisfaction with FP services received, there were wide variations in opinions across providers and managers with regard to the perceived levels of client awareness of their rights. To address this, it is key that the policy environment at the national level be supportive of rights-based FP services. Development and implementation of a national strategy on rights-based FP will help support increased awareness of clients' rights at the provider, manager, client, and community levels. To promote sustainability, implementation of the strategy should be embedded in all FP programs led by both the departments and development partners collaboratively through a consultative process, including development of localized implementation plans.

Recommendation 2: Strengthen the enabling environment for frontline health actors

It is important that health facilities not operate in isolation from the adjacent communities they are serving. However, one of the issues coming out clearly from the study findings is the challenge of insufficient coverage of LHWs and male mobilizers, who play a central role in supporting optimal FP practices at the community level. Given the limited numbers, their ability to reach all families requiring their services is compromised. Providers further mentioned the need for more efforts to reach men, mothers-in-law, and religious leaders to improve their support for FP, as well as more focus on household visits and provision of FP information and services at outreach camps. Male spouses echoed a desire to have easier access to information about FP, using channels that work for them, such as home visits, community events, or social media.

To address this, efforts to increase both the FP capacity and coverage of LHWs and male motivators, especially in hard-to-reach areas, is critical. Stronger links need to be established between the communities and health facilities, with community actors serving as a link between the two.

At the community level, strengthening community-based FP services and improving the capacity of community workers will have a positive impact on provision of information and services and for addressing the prevalent misconceptions surrounding FP. Improving the capacity of LHWs and male mobilizers will enable them to capitalize on the contacts that they already have with mothers, fathers, and family members to provide comprehensive FP information and services.

Recommendation 3: Increase community leadership in health

To promote sustained improvements in the quality of health care, communities must be engaged as active leaders in health solutions rather than as passive "beneficiaries" of health services. Community leadership in health is crucial to improving the quality of health services.

The study highlighted how powerful word of mouth at the community level is in influencing opinions about FP methods. It showed that oftentimes there are gaps and inaccuracies in information shared between peers/nonhealth professionals, and information may be distorted as it flows from person to person. Our findings also highlight the need to address key misconceptions around side effects. Several providers also mentioned the power of positive client experiences for motivating others to use FP, and communication through social networks was also seen to play a positive role when satisfied users share their experiences with others in the community.

To address these gaps, and capitalize on the opportunities, community-level interventions should seek to provide more opportunities for community engagement on FP, including creating space for active dialog between communities and health facilities. Interventions should include discussions on client rights, household decision-making, and capacity-building of community champions, satisfied clients, and religious and community leaders.

Recommendation 4: Develop and integrate strategies to better reach men with FP information and services

Men play a key part in their own and their family's health, yet they are often neglected in outreach and service delivery. The involvement of fathers before, during, and after the birth of a child has been shown to have positive effects on violence reduction, improved maternal health outcomes, breastfeeding, the use of contraceptives and health services, and fathers' long-term support for their children (WHO 2007). This study reported that husbands play a critical role in contraceptive decision-making, yet respondents recognized a lack of opportunities for men to learn about and discuss FP.

To address these gaps, specific and purposeful gender activities must be targeted at the entire health system. It is critical to build the capacity of providers to engage men in FP counseling and services and support them to work with their partners to decide family size. This includes supporting implementation of the updated National Action Plan for FP, while includes an enhanced role for male mobilizers. At the community level, strategies need put in place to facilitate couple and community dialogs to transform harmful gender norms that act as barriers to positive health outcomes. Social and behavior change strategies also need updated to focus on addressing myths and misconceptions specific to men (and mothers-in-law, where possible). The use of digital and mass media could complement community events and engagement.

Engaging men as clients, supportive partners, and champions of gender equality can contribute to improvements in gender equality, couples decision-making, and the utilization of health services. This in turn leads to better health outcomes for men, women, and their families.

Recommendation 5: Continue to build provider skills and confidence in counseling/provision of the full range of contraceptive options and addressing client complaints of side effects

An onsite clinical capacity-building approach, coupled with supportive supervision, is recommended. Onsite capacity-building promotes sustained increases in health provider performance. Traditional training approaches that use offsite, large group workshops are not effective in improving and maintaining health worker performance following the training. Evidence increasingly suggests that learning within the workplace in short segments with frequent practice is more effective at impacting performance in the long term and supports improvements in health worker capacity to meet quality of care standards in the short term.

While providers discussed counseling clients on a range of FP options and their side effects, many requested additional training (particularly for implants and IUDs), and not all were competent in the full range of methods or managing side effects for certain methods. Service providers described strategies to address barriers to uptake and facilitate use, including focusing on providing high-quality counseling and rapport building, and incorporating discussion of alignment with religious values.

Health service providers should receive additional training and support to improve their counseling skills and service delivery practices surrounding FP. This will require incorporating opportunities for values clarification to address perceptions hindering high-quality service provision. It is also important to recognize the good work of high-quality FP service providers and to revisit monitoring and supportive supervision mechanisms to ensure they include more oversight of areas with regards to providers' skills, values, and preferences.

Recommendation 6: Assess the role of provider FP method preferences in service delivery

Providers all have unique backgrounds which influence their understanding and implementation of services. Sometimes deeply ingrained cultural and religious beliefs of the service providers themselves can lead to biases against or for a particular method.

When asked about preferred contraceptive methods, many providers did indicate that they had specific methods that they prefer to recommend and some that they did not prefer. These preferred methods varied by provider and were based on ease of use by the client, availability at the health facility, acceptability to male partners, and community preferences. These preferences may affect the methods providers emphasize during client counseling.

Because study findings suggest that much of the provider bias in this context was related to either misconception about side effects or the perceived ease/difficulty in providing certain FP methods, it is recommended that these be addressed by (1) providing comprehensive training on the full range of FP methods, moving beyond conventional training content to also address the underlying norms, attitudes, values, and beliefs that impact provider behavior (2) ensuring health workers have reference materials for counseling clients, and (3) providing post-training support and supervision to improve/ maintain provider performance after training.

Provider behavior toward clients is influenced by many factors, including values, social and gender norms, supervision, skills, knowledge, and structural context. Thus, it is important to address not just external motivation and provider skill factors, but also address internal or intrinsic motivating factors. Internal motivations are diverse and include personal attitudes and beliefs, social and gender norms, personal and community values, status within the community and within the health system, perceived importance of work, recognition, and feelings of connectedness and social cohesion among supervisors and peers, including within and across sexes. Consider how to apply emerging programming lessons to promote provider behavior change, and ways to more broadly address these factors via social and behavior change communication interventions that place providers as the audience.

Recommendation 7: Address Contraceptive Stock-Outs

There were variations in provider responses regarding contraceptive stock-outs, with some indicating stock-outs had not posed a problem and others indicating stock-outs were a critical barrier to FP uptake at their facility. Addressing stock-outs across facilities is a key component to ensuring access to high-quality, rights-based FP information and services.

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