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Original Research Article

IMPORTANT REASONS FOR REFUSAL OF CONTRACEPTION AND THEIR FREQUENCY AND AWARENESS OF CONTRACEPTION AMONG LOW TO MIDDLE-INCOME POPULATION

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Abstract: *Contraception is a cornerstone of public health initiatives aimed at reducing unplanned pregnancies, improving maternal and child health outcomes, and empowering individuals to make informed reproductive choices.* ***Objective:*** *To identify the primary reasons for contraception refusal, assess the frequency of refusal, and evaluate awareness of contraceptive methods among individuals in low- to middle-income communities.* ***Methods:*** *This cross-sectional study was conducted at Shaikhzaid Women's Hospital Larkana from June 2024 to November 2024. Data were collected from 1200 participants. Participants were selected based on their willingness to participate and their ability to provide informed consent. Both men and women were included in the study to capture a broader understanding of contraceptive use, refusal, and awareness.* ***Results:*** *The study involved a total of 1,200 participants, with a majority of 800 females (66.7%) and 400 males (33.3%). The predominant age group was 25–35 years, accounting for 60% (n=720) of the sample, followed by 18–24 years at 25% (n=300) and 36–45 years at 15% (n=180). Regarding monthly household income, 70% (n=840) of participants reported incomes below the regional average, while 30% (n=360) had incomes above the regional average, highlighting the economic constraints faced by the majority of the population. Awareness of contraceptive methods was high for short-term options, with 75% (n=900) of participants knowing about condoms and 68% (n=816) aware of oral contraceptive pills. However, awareness of long-term methods like implants (40%, n=480) and intrauterine devices (35%, n=420) was relatively low, and only 20% (n=240) were familiar with emergency contraception.* ***Conclusion:*** *It is concluded that contraception refusal among low- to middle-income populations is influenced by a combination of cultural, economic, social, and informational barriers. Cultural and religious beliefs emerged as the most significant factors, followed by misconceptions about side effects and economic constraints.*

Keywords: Contraception, Family Planning Services, Health Knowledge, Attitudes, Practice, Socioeconomic Factors, Cross-Sectional Studies

Introduction

Contraception is a cornerstone of public health initiatives aimed at reducing unplanned pregnancies, improving maternal and child health outcomes, and empowering individuals to make informed reproductive choices. However, to date, the usage of contraceptives is not very widespread, particularly in low to middle-income populations. Such non-use of contraception in these communities has several factors: cultural, religious, lack of information, or lack of access to antiretroviral services (1). Many of these barriers are fueled by socioeconomic disparities, gender inequalities, and poor knowledge about contraception techniques or fertility advantage in each method available. The other reasons why people refuse to use contraceptives include societal and religious beliefs. In many low- to middle-income countries, culture and religion disapprove of contraceptive use, for it is considered sinful or is interpreted as a lack of faith in God's providence (2). This is because religious heads and cultural practices have a critical influence over any given society to remind the latter that family planning disrupts natural orders. These perceptions are cognitive and implicit, making some groups of people decline to use modern contraceptive methods, especially in conservative environments (3).

Ignorance and misconceptions about contraceptives are another key factor as well. These people have concerns about the effects of contraceptive measures like disabilities in bearing children again, gain in weight, and hormonal imbalances. That is why such misconceptions arise mainly on the background of the lack of proper sex education and the lack of literate sources of information (4). This is even worse in rural and other less-served areas because people cannot get the healthcare they need from skilled personnel or through readily available clinics where proper information can be given to the affected parties. Another social determinant of contraception refusal is socioeconomic status. Contraceptive costs, for example, implants or IUCDs, may be unreasonably high for families with low income levels (5). Despite the availability of some services at little or no cost to the individual through government or non-governmental organizations, there are barriers like cost implications related to clinic transport and time lost from work. Moreover, the male partners may strongly resist the use of contraceptives by their female partners, with some arguing that it is not needed or claiming that the use of contraceptives is an undermining of their role at home (6). Social relations add to this by the fact that most women in patriarchal societies lack control over decisions

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of reproduction. In such contexts, decision-making on family planning falls under the domain of the male partner, and the woman or girl may have a perception that she can be beaten up or that she will be ostracised from her community if she takes a commercial diet without consulting her partner (7). It is, therefore, essential for gender-specific efforts to promote family planning campaigns to be initiated and with both the male and female populations addressed. Knowledge of contraceptives is another crucial determinant of its usage. Low to middle-income populations are often not well-informed or educated on adequate reproductive health and contraceptive choices (8). This lack of knowledge confuses understanding of how the various methods function and their safety and efficiency. These topics are not well taught in school-based programs, and cultural barriers deter discussions of sexuality and reproductive health (9). Combating these things is complex, but it must be done that way. Family planning is an important area that requires culturally sensitive public health education campaigns to clear myths and inform couples of the importance of family planning and decision-making. Religious people should be encouraged to encourage the use of contraceptives within religious norms (10). In addition, counseling, increasing the availability of affordable contraceptives, and incorporating family planning facilities into primary health care have potential solutions to logistic and resource constraints issues. Saying 'yes' to contraception and low knowledge among low to middle-income groups is multi-faceted, cultural, economic, and social barriers. Work to overcome them has to be informed by an appreciation for the experiences of these populations. Through awareness campaigns, eradicating misconceptions, and cheap access to contraceptives, we can, in a way, make people realize their reproductive needs and desires, thus enhancing their reproductive health and, hence, society's health (11).

The objective of the study was to identify the primary reasons for contraception refusal, assess the frequency of refusal, and evaluate awareness of contraceptive methods among individuals in low- to middle-income communities.

Methodology

This cross-sectional study was conducted at Shaikhzaid Women's Hospital Larkana from June 2024 to November 2024. Data were collected from 1200 participants. Participants were selected based on their willingness to participate and their ability to provide informed consent. Both men and women were included in the study to capture a broader understanding of contraceptive use, refusal, and awareness. Individuals aged 18–45 years. Participants who were sexually active or in a relationship where contraception use was relevant. Willingness to provide informed consent. Individuals with a medical condition contraindicating contraceptive use. Patients who were pregnant at the time of data collection. Data were collected using structured questionnaires. The questionnaire was designed to explore participants' demographics, awareness of various contraceptive methods, and the reasons for refusing contraception. It also delved into household decision-making dynamics, focusing on whether individuals experienced opposition or pressure from partners or family members. Questions covered knowledge of oral pills, condoms, intrauterine devices, implants, and natural methods, as well as participants' sources of information and perceptions regarding the effectiveness and safety of these methods. The study received ethical approval from the institutional ethics committee before its commencement. Participants were provided with detailed information about the purpose and nature of the study, and informed consent was obtained in writing from all individuals.

Data were analyzed using SPSS v26. Descriptive statistics were used to summarize demographic data, levels of awareness, and reasons for refusing contraception. In addition, chi-square tests and logistic regression analyses were performed to examine the association between demographic factors and contraception refusal or lack of awareness.

Results

The study involved 1,200 participants**,** with a majority of 800 females (66.7%) and 400 males (33.3%). The predominant age group was 25–35 years, accounting for 60% (n=720) of the sample, followed by 18–24 years at 25% (n=300) and 36–45 years at 15% (n=180). Regarding monthly household income, 70% (n=840) of participants reported incomes below the regional average, while 30% (n=360) had incomes above the regional average, highlighting the economic constraints most of the population faced.

Awareness of contraceptive methods was high for short-term options, with 75% (n=900) of participants knowing about condoms and 68% (n=816) aware of oral contraceptive pills. However, awareness of long-term methods like implants (40%, n=480) and intrauterine devices (35%, n=420) was relatively low, and only 20% (n=240) were familiar with emergency contraception. Among the 600 participants who refused contraception, the primary reasons were cultural or religious opposition (40%, n=240) and fear of side effects (30%, n=180)

Among women, 60% (n=480) reported making joint decisions with their partners, while 35% (n=280) stated their partners had the final say. Only 5% (n=40) of women reported making independent decisions about contraception. In contrast, 80% (n=320) of male participants believed in mutual decision-making, though this did not always align with women's responses, highlighting the influence of gender roles in family planning decisions.

Healthcare providers were the primary source of contraceptive information, cited by 50% (n=600) of participants. Social networks, including family and friends, contributed to 30% (n=360) of the information. School-based education accounted for 10% (n=120), while media channels such as TV, radio, and the Internet provided information to 8% (n=96) of participants.

Concerns about perceived side effects were significant among participants, with 40% (n=480) fearing infertility and 30% (n=360) associating contraceptive use with weight gain. Hormonal imbalances were a concern for 20% (n=240), while reduced libido was reported by 6% (n=72). Other side effects, such as nausea and headaches, were noted by 4% (n=48).

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Table 1: Demographic Characteristics of Participants

Characteristic	Frequency (n)	Percentage (%)
Gender		
Female	800	66.7%
Male	400	33.3%
Age Group		
18–24 years	300	25%
25–35 years	720	60%
36–45 years	180	15%
Monthly Household Income		
Below regional average	840	70%
Above regional average	360	30%

Table 2: Awareness of Contraceptive Methods

Contraceptive Method	Awareness (n)	Percentage (%)
Condoms	900	75%
Oral contraceptive pills	816	68%
Implants	480	40%
Intrauterine devices (IUDs)	420	35%
Emergency contraception	240	20%
Reason for refusal		
Cultural or religious opposition	240	40%
Fear of side effects	180	30%
Partner opposition	90	15%
Economic barriers	60	10%
Lack of access or information	30	5%

Table 3: Decision-Making Dynamics

Decision-Making	Frequency (n)	Percentage (%)
Joint decisions (women)	480	60%
Partner has final say (women)	280	35%
Independent decisions (women)	40	5%
Belief in mutual decision-making (men)	320	80%

Table 4: Sources of Contraceptive Information

Source	Frequency (n)	Percentage (%)
Healthcare providers	600	50%
Social networks (family/friends)	360	30%
School-based education	120	10%
Media (TV, radio, internet)	96	8%
Others (community programs)	24	2%

Table 5: Awareness of Side Effects of Contraceptive Methods

Perceived Side Effect	Frequency (n)	Percentage (%)
Infertility	480	40%
Weight gain	360	30%
Hormonal imbalances	240	20%
Reduced libido	72	6%
Other (e.g., nausea, headaches)	48	4%

Discussion

This study aimed to explore the reasons for refusal of contraception and the awareness levels among low- to middle-income populations. This study showed that cultural and economic constraints interacted with social and informational factors to determine contraceptive behavior. Taken together, these results highlight the importance of intervention efforts for increasing contraceptive use and knowledge in underserved groups. In pre-COGS assessments, cultural and religious beliefs were the most common reasons for either partial or complete contraception refusal, accounting for 40 percent of all reasons (12). This shows the aspects of culture and religion that have disapproved of family planning for many years. Thus, people often have a notion that contraception violates natural or divine provisions. These results are in enumeration with similar earlier Pointing studies that have

highlighted the cultural and religious factors as the main determinants of contraceptive use among similar ethnic groups. To meet these needs, culturally acceptable health-promoting interventions, including the use of religious and community leaders to push for acceptance of contraception, must be pursued (13).

Another reason 30 percent refused was because they feared side effects. Some people thought that contraceptives had adverse side effects that included causing infertility, weight gain, or hormonal imbalance (15). Such perceptions may be shaped by insufficient information on sex and healthcare services and poor provision of healthcare in developing countries. These sequencing patterns have been reported in different works, indicating that misinformation considerably impacted people's readiness to use family planning methods (16). These fears should be combatted by enhancing the flow of good information relating to sex through doctors, media, and Sex education in schools. This included 10 percent quoting economic factors in refusing to heed contraception measures. Though many governments and organizations offer affordable, preventive contraceptives, additional costs like transportation and time off work put them off (17). Additionally, 5 percent of participants stated they had little access to information. These observations point to the need for the expansion of permanent family planning services within the framework of primary health care and their accessibility in conditions of lack of availability of specialized family planning services in distant and poorly populated areas (18).

The study showed a discriminating distribution of power on matters related to contraception. Of the women, 35 percent concluded that their husbands had the last word on such decisions, and only 5 percent made such decisions independently. These results prove Patriarchal norms influence reproductive health behaviors. In this case, both partners should be encouraged to embrace a family planning project to hear both of them before a decision is taken (19). Other equally essential programs are those that target informing women about reproductive choices. As highlighted in this study, the following are the recommendations to increase contraception use and knowledge in the low-middle-income groups. These are culturally appropriate, including concern programs, religious leaders, men of faith, increasing access to affordable contraception services, and public enlightenment to erase common myths about the side effects and benefits of family planning (20). This work examines the complex factors behind why people refuse contraceptives and how the level of knowledge differs from the low and middle earners. These barriers cannot be solved independently of culture, economics, and social systems. By promoting education and increasing access to and the involvement of the communities in decision-making, it would be possible to operate on the causes that would improve or adjust the usage of the family planning methods and contribute to improved health of these communities and their quality of life.

Conclusion

It is concluded that contraception refusal among low- to middle-income populations is influenced by a combination of cultural, economic, social, and informational barriers. Cultural and religious beliefs emerged as the most significant factors, followed by misconceptions about side effects and financial constraints. Awareness of contraceptive methods was generally limited to short-term options, with a considerable lack of knowledge about long-term and emergency contraceptive methods.

Declarations

Data Availability statement

All data generated or analyzed during the study are included in the manuscript.

Ethics approval and consent to participate

Approved by the department concerned. (IRBEC-TCMMP-02324/23)

Consent for publication

Approved

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Conflict of interest

The authors declared the absence of a conflict of interest.

Author Contribution

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Conception of Study, Development of Research Methodology Design, Study Design, manuscript Review, and final approval of manuscript.
Conception of Study, Final approval of manuscript.
SHAISTA JUNEJO (Woman Medical Officer)
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