

Contraceptive Decision Making in Females Visiting Outpatient Department of Obstetrics and Gynaecology, Nishtar Hospital Multan

HAFIZA SAIMA NASEEM, KHADIJA KHALIL, SHAHIDA AZIZ, MARIA ZAHOOR

ABSTRACT

Aim: To determine primary decision maker regarding contraception in females.

Study design: Descriptive cross sectional study.

Place and duration of study: Department of Obstetrics and Gynecology Unit I, Nishtar hospital Multan. Six months from 06th August 2010 to 05th February, 2011.

Methods: A total of 384 patients were included in this study. With the help of questionnaire patients were inquired about their education, occupation, residential status, about any previous method of contraception being used, and who was the decision maker regarding contraception.

Results: Mean age of patients was observed to be 36.4±4.9. Distribution of cases by parity showed, 237 patients (61.7%) were para 1 -4 and 147 patients (38.3%) were para 5-7 with mean of 5.1±2.7. Out of 384 patients, 118(30.7%) used contraceptive methods.

Conclusion: Husband is the primary decision maker regarding contraception in our female population, so spouses should be actively involved in counseling sessions.

Key words: Contraception, decision making.

INTRODUCTION

Pakistan, with an estimated population of around 180 million, is the seventh most populous country in the World¹. According to UN, Pakistan will be the fourth most populous country by the year 2030 if population continues to grow at this pace². Family planning has important implications in population dynamics as unregulated fertility adversely affects the economic stabilization of Pakistan which is a developing country with limited resources³. Family planning is also important to improve the health of the mother and the child and to reduce maternal and perinatal mortality⁴. A large majority, 97% of Pakistani women know at least one method of contraception⁵. However, total contraceptive prevalence rate (CPR) of Pakistan is 29%⁶. Thus there is a considerable gap between knowledge of contraception and its implementation. Major obstacles to reducing fertility in Pakistan include social and religious objections to family. The WHO has led the development of decision making tools for family planning to improve the quality of family planning counselling⁷. To make effective effort one must have to work on individual as well as community level.

In our families men play a dominant role, so they must be involved in counseling process⁸. In Vietnam, it was observed that male's involvement in decision

making significantly increased the use of contraceptive methods by their wife⁹. Similarly, in Oman, it was found that the women who were interviewed, 50% of them said that their husbands decided about their contraception⁽¹⁰⁾. Mother-in-law also plays an important role in determining size of family and pressurizes newly married couples to have a child early¹¹. Ideally decision about contraception should be made jointly by the couple¹². In our society generally, women who are more than 30 years of age and having four or more children are more inclined towards contraception¹³.

Major obstacles towards reducing fertility include lack of consistent government commitment towards provision of family planning services, and social and religious objections¹⁴. Understanding of the decision making dynamics and identification of decision-maker regarding fertility is crucial and important if these obstacles are to be addressed.

The proposed study aims to assess the actual person responsible for decision making regarding contraception in family, so that we will be able to make our family planning programmes more effective and successful by targeting them.

METHODOLOGY

A total of 384 patients visiting outdoor department of obstetrics and gynaecology, fulfilling inclusion criteria were selected in the study. The study was done with permission of ethical committee of the institution. Patients having handicapped babies and those with

Department of Obstetrics & Gynaecology, Nishtar Medical College/Hospital, Multan

Correspondence to Dr. Hafiza Saima Naseem Email: drtariqwaqar@yahoo.com

medical disorders were excluded from the study by taking history and reviewing their previous medical records. Through a questionnaire patients were inquired about their education, occupation, residential status, previous method of contraception and who was the person to decide about contraception. All information was collected in a specifically designed questionnaire.

Data was analyzed by SPSS version 10. Descriptive statistics were used to analyze the data. Mean and standard deviation were calculated for age and parity. Frequency and percentages were calculated for primary decision makers. Data obtained was presented in tabulated form. It was a descriptive study so no statistical test was needed to apply. Stratification was done regarding age, parity, occupation to see effect of these on outcome.

RESULTS

This study was conducted on 384 patients attending gynaecology and obstetrics outdoor clinic. Regarding age distribution of patients, 247 patients (64.3%) were between 30-35 years of age, 89(23.2%) were 36-40 years old, while 48 patients (12.5%) were between 41-45 years of age with mean age of 36.4±4.9 (Table 1). Distribution by parity showed 237 patients (61.7%) were para 1-4 and 147 (38.3%) were para 5-7 with mean of 5.1±2.7 (Table 2). By occupation, housewives were 331(86.2%) while remaining 53 patients (18.8%) were working women (Table 3). Majority of patients were uneducated i.e., 247(64.3%), 34 (8.9%) had primary level education, 44(11.5%) had middle level education, 38(9.9%) had matriculation level education and 21(5.4%) women had higher education (Table 4). Out of 384 patients 118(30.7%) used contraceptive methods (Table 5). Primary decision makers were husband in 70(59.3%) cases, while in 26(22%) it was women herself and mother-in-law and mother in 15(12.7%), 7(6%) cases respectively (Table 6).

Table 1: Age distribution of patients (n=384)

Age (in years)	n	%age
30-35	247	64.3
36-40	89	23.3
41-45	48	12.5
Total	384	100.0

Mean age ±S.D.=36.4±4.9 years.
Age range = 30–45 years.

Table 2: Parity distribution of patients (n=384)

Parity	=n	%age
Para 1-4	237	61.7
Para 5-7	147	38.3
Total	384	100.0

Mean parity ± S.D. = 5.1±2.7.

Table 3: Distribution of cases by occupation (n=384)

Occupation	=n	%age
Housewife	331	86.2
Working women	53.	18.8

Table 4: distribution of cases by education (n=384)

Education	n	%age
Uneducated	247	64.3
Primary	34	08.9
Middle	44	11.5
Matric	38	09.9
Higher education	21	05.4

Table 5: distribution of cases by use of contraception (n=384)

Use of contraception	n	%age
Yes	118	30.7
No	266	69.3

Table 6: Distribution of cases by primary decision maker of contraception (n=384)

Decision maker	n	%age
Husband	70	59.3
Herself	26	22.0
Mother-in-law	15	12.7
mother	07	100.0

DISCUSSION

Inspite of being one of the first countries in South Asia to launch a national family planning programme, Pakistan is exceptional in terms of its poor performance in improving contraceptive prevalence. After nearly three decades of government sponsored family planning programmes, contraceptive prevalence has only increased from 5% in 1974-1975¹⁵ to 25% in 1996-1997¹⁶. Paradoxically, a significant proportion of women do not wish to have additional children¹⁷.

In the South Asian patriarchal and extended family norm of social life, women are taught that their own interests are subordinate to those of the family group, and consequently they are likely to discount their own desire to regulate fertility¹⁸. This translates to poor inter-spousal communication, a factor cited to have an important bearing on fertility control^{19,20,21}. In the joint family system, the mother-in-law is also considered a major impediment to family planning^{22,23}. Further, in Pakistan where more than 90% of the population is Muslim, traditional and religious beliefs are largely based on individual interpretations of Islamic law, and its tenets inhibit the use of family planning.

Limited research has been conducted on the decision-making process and inter-spousal communication for matters related to family planning in Pakistan. All respondents reflect attitudes of a

patriarchal society where female mobility is restricted and where women are not supposed to talk to men and prefer to have a female counselor when alone or even if the couple were being counseled together.

Our study showed that contraception was used by 118(30.7%) of couples, of these 118 primary decision maker were as followings: husband 70(59.3%), herself 26(22%), mother-in-law 15(12.7%) and mother 7(6%). Husband plays an important role as an independent decision maker or as an important member of decision making group in the family. Most of the women in our study had no formal education; also most of them were housewives.

The dominance of acceptability and husband's attitudes is consistent with our interpretation and, on the whole, with previous research results carried out in Pakistan. The existing literature is, to some degree, ambivalent as to whether husbands' attitudes, expressed or perceived, constitute a major barrier to Pakistani women's ability to implement their fertility preferences by practicing contraception. The variables concerning husbands' views are derived entirely from interviews with their wives; that is these are wives' perception of the attitudes and preferences of their husbands.

The role of communication between husband and wife on desired fertility and, consequently, on contraceptive use is well established^{24,25,26,27,28}. Inter-spousal communication has been recognized as a key factor for adoption and sustained use of family planning, because it allows couples to discuss what might appear unclear and exchange information that may change strongly held beliefs^{25,27,29}.

The concept of family planning has raised some concerns regarding its acceptability within Muslim population³⁰. The present study showed that women had positive attitude and awareness of the different methods of contraception. This may be due to economic constraints and awareness of the benefits of small families. Awareness for contraceptive usage is valuable only if the information obtained is correct and utilized appropriately³¹. Strategies to increase contraceptive use must include improving delivery of correct and adequate information about the available contraceptive methods.

Thus we subscribe to the view (Bongaarts and Bruce) that changes in family planning behaviour can be brought out by changing value systems and creating awareness about Circumstances and family planning¹⁹. The pace of fertility decline in Pakistan can be enhanced by helping the society, particularly the males, to better understand Islamic teaching on fertility control, and providing family planning education simultaneously. Change in attitude is likely to occur when a clear understanding is given that

Islamic laws do not prohibit the use of contraceptive but are rather permissive with regard to family planning³².

The stronger a man's sense that family planning use is a responsible behavior because it improves his wife's health and his family's economic well-being, the more likely he is to use contraceptive methods. Such a strategy may be particularly important in rural Pakistan, where a recent study found a much faster growth of traditional methods than of modern methods³³.

The findings are consistent with findings from the 2006-07 demographic and health survey regarding reasons for non use among women who do not intend to use contraception in future; the two most important reasons were that fertility was up to GOD (28%) and the husband was opposed to family planning methods use (10%)³⁴. In Pakistan, perceived lack of women's control over decision making regarding family planning highlights the importance of persuading husbands to use contraception and to discuss contraceptive use with their wives.

Education is considered to acquire greater power in decision-making³⁵. The use of contraception is higher in urban areas and among women with higher level of education. Contraceptive use increases from 16% of currently married women in the lowest wealth quintile to 43% of those in the highest quintile⁶. Wijisen et al demonstrated that education level is related to contraceptive method choice and consistent use of chosen method³⁶. This was not the case in our study probably because of smaller sample size of the study, however needs further research in this area to see the affect of education and higher social class.

When a health professional has actively involved the women in decision making process, she is less likely to use contraception inappropriately³⁷. It is important that women are adequately informed by the health professionals about possible alternative contraceptive methods, especially for younger and less educated women, inadequate information may result in a less vigilant decision. This study has some limitations. The sample size was small. Secondly, women came alone so male partners were not directly involved in the study. Although possible efforts were made to obtain the correct information, the possibility of misreporting can not be ruled out keeping in mind the low female literacy rate.

CONCLUSION

Primary decision maker is husband in most of the cases so they should be actively involved in family planning counseling. Furthermore, the information,

education and communication of family planning should also target mother-in-laws in addition to spouses to enhance contraceptive use. Religious leaders should also be involved in this circle. Health professionals must provide accurate, updated and adequate information. While as long term measures women's education level must be increased to make family planning campaign a real success.

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