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Socio-Demographic Factors Associated with Knowledge and Acceptance of Contraceptive Methods

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ABSTRACT

Background: Too frequent conceptions may be incompatible with health and socioeconomic resources of the parents. **Objective:** To study socio-demographic factors associated with knowledge and acceptance of contraceptive methods.

Material and Methods: This community based cross sectional study was carried out among married women of reproductive age in field practice area of Rohilkhand Medical College and Hospital Bareilly. The study period was November 2014 to October 2015. Simple Random Sampling was used.

Results: Majority of respondents have found that there are no social or cultural problems during their contraceptive usage, it was also seen that majority of the respondents in study group have observed no stigma or harm in the usage of contraceptives.

Conclusion: The knowledge regarding contraceptives and its use varied with socio-demographic characteristics of the population like age, religion, education, socio-economic status.

Keywords: Socio-Demographic Factors, Knowledge, Acceptance, Contraceptive Methods.

INTRODUCTION

Too frequent conceptions may be incompatible with health and socioeconomic resources of the parents. If there are too many children in a poor family, they are deprived of adequate care and tend to be ill-nourished and unhealthy. Large family size adversely affects the health and happiness of each member of the family.

By protecting women from the risk of pregnancy and its associated complications, family planning can play a vital role in the reduction of infant, child and maternal morbidity and mortality. By preventing unwanted or mistimed pregnancies, family planning can also reduce abortions by unskilled providers or under unhygienic conditions. However, the benefits of family planning go beyond improvements in maternal and child health. For girls and women, for example, family planning can result in higher educational attainment, better employment opportunities, higher socioeconomic status and empowerment.[1]

A number of factors influence contraceptive use such as woman's age, her level of education, religious beliefs, place of residence- whether rural/urban, parity, socio economic

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class, number of living children, number of male children, availability and accessibility of services, cost of services, attitude of woman, husband, family members, side effects, failure of contraceptives and inter-spouse communication. Good communication between husband and wife influences the decision making process between couples for adoption of health practices. Inter- spouse communication about family planning influences their contraceptive choices and practices.[2]

Good socioeconomic condition is conductive for better acceptance of small family-norm resulting in low fertility and vice versa, i.e. a better performance in family planning and low fertility results in better socioeconomic conditions, thus one influencing the other. The indicators of socioeconomic development are per capita GNP, adult literacy rate and life expectancy at birth. The indicators for the performance in family planning services are percentage of eligible women using contraception, total fertility rate and crude birth rate. Social consequences of not adopting family planning would be poverty, illiteracy, unemployment problem, living problems, prostitution, antisocial activities like theft, murder, juvenile delinquency, etc.

The health of the family and family planning are related in such a way that one gives boost to the other.

Even though pregnancy is a normal physiological process, it is associated with a great pathological potential, resulting in increased maternal morbidity and mortality. MMR in developing countries is 15 to 20 times higher than that of developed countries. Adopting family planning directly reduces MMR, by improving women's health (by having only one or two children with spacing, it prevents the depletion of maternal reserve, thus promoting her health.

An association between advanced age of the mother and some congenital anomalies like Down's syndrome has been well documented. Similarly, the incidence of abortion and still birth is more among teenage pregnancies. Thus, adopting family planning and conceiving in the right age of the mother, improves foetal health.

Small differences in the family size will make big differences in the birth rate. The difference of only one child per family over a decade will have a tremendous impact on the population growth. The objective of the family welfare programme in India is that people should adopt the "small family norm" to stabilize the country's population at the level of some 1533 million the year 2050 AD. Symbolized by the inverted red triangle, the programme initially adopted the model of the 3- child family. In the 1970's, the slogan was the famous "DO YA TEEN BUS". In view of the seriousness of the situation, the 1980's campaign has advocated the 2- child norm. The current emphasis is on three themes: "Sons or Daughters-two will do"; "second child after 3 years", and "universal Immunization".[3]

Hence this study was conducted to study socio-demographic factors associated with knowledge and acceptance of contraceptive methods.

MATERIAL & METHODS

This community based cross sectional study was carried out among married women of reproductive age infield practice area of Rohilkhand Medical College and Hospital Bareilly. The study period was November 2014 to October 2015. Simple Random Sampling was used.

Inclusion Criteria

All married women in the reproductive age group in the study area.

Those who have given informed consent.

Exclusion Criteria

- Persons not giving their consent for the study.
- Married women who have crossed their reproductive age.
- Unmarried women/widowed/divorced.

ISSN: 0975-3583, 0976-2833 VOL 13, ISSUE 08, 2022

Sample Size calculation

Using Formula - $\frac{4pq}{L^2}$

p=50% (prevalence of knowledge, attitude and practice of contraceptive use)

q= (100 – p) = 50

L= (allowable error) =10%

Substituting the values: $\frac{4 \times 50 \times 50}{5 \times 5}$

= 400

P = Prevalence of 50% was taken, as exact prevalence was not known, so we took anticipated prevalence as 50% and calculated the sample. After simple random sampling, total 408 participants were interviewed. Therefore, total sample size was 408.

An elaborated Pretested, predesigned Schedule schedule was prepared by the investigator before undertaking the study. Schedule was also prepared in vernacular language. It was validated after extensive review by guide and co guides for criterion validity and by carrying out pilot study with a sample of 40 subjects for reliability. Those 40 subjects were not included in the main study. Both open and close-ended, pretested semi-structured interview schedule was be prepared.

Methodology: After taking approval from Institutional Ethical Committee, study was conducted in urban & rural field practice area. All the houses in each area were numbered and all households with married women were included in sampling frame. 408 houses were chosen by simple random sampling. In case of more than one woman in selected house, one woman of reproductive age were chosen by using Simple Random Sampling till desired sample size will achieve. After taking consent, interview was taken by the author himself. Purpose of study was explained and assurance was given regarding confidentiality of identity. Questions were asked in vernacular language for better understanding by respondents.

RESULTS

Most of the respondents lie in the age group of 24-29 (54.41%), followed by 30-35(31.61%), and the least number of respondents were of age more than 35. In terms of educational status, maximum number of respondents were illiterate (38.97%), and minimum were intermediate pass (1.96%). Table 1

Same trend follows in the educational status of Husband of respondents i.e. maximum respondents were illiterate (26.0%) and minimum were intermediate (10.5%).

Maximum number of respondents were housewives (85.53%), rest were rather divided equally in other occupational groups.

In terms of income maximum respondents (81.36%) have income less than Rs. 10000.

Religion wise Hindus constitute the majority (71.07%) followed by muslims (25.98%).

Regarding family size and type maximum respondents were from joint family type and having family size of 5-8 members.

According to respondents from which source they experienced social and cultural problems during their contraceptive usage, in this table majority (91.4%) have found that there are no social or cultural problems during their contraceptive usage, a small group of respondents were facing social and cultural problems from family members(3.7%), friends(3.4%), and society(1.5%).

ISSN: 0975-3583, 0976-2833 VOL 13, ISSUE 08, 2022

Table 1: According to respondents from which source they face social and cultural problems during their contraceptive usage

Source	Frequency	Percentage
Family members & relative	15	3.7%
Friends	14	3.4%
Society	6	1.5%
None	373	91.4%
Total	408	100.0%

Majority of the respondents in study group (69.1%) have observed no stigma or harm in the usage of contraceptives. Then there were respondents who don't know (26.2%) about any associated stigma or harm. There are 4.7% of respondents who replied in favour of association between stigma or harm and contraceptive usage.

Table 2: According to respondents is there any stigma or harm associated with use of contraceptives (n=408)

Stigma or harm associated with use of contraceptives	Frequency	Percentage
Yes	19	4.7%
No	282	69.1%
Don't Know	107	26.2%
Total	408	100.0%

Majority (69.1%) of respondent females have found no stigma or harm in association with usage of contraceptives. Then there were respondents who don't know (26.2%) about any associated stigma or harm. Among the respondents 3.68% have sought stigma or harm is associated with health. 1% of the respondents in study group have found social stigma is associated with use contraceptives.

Table 3: According to respondents which type of stigma or harm is associated with the use of contraceptives (n=408)

Stigma or Harm	Frequency	Percentage
Health related	15	3.68%
Social stigma	4	1.0%
Don't Know	107	26.2%
None	282	69.1%
Total	408	100.0%

23.0% respondents in this study will recommend OCP to their friends or relatives, 26.5% will recommend condom. Permanent methods of contraception i.e. female sterilization and male sterilization will be recommend by 7.1% and 1.7% of users respectively. IUDs and Injectable contraceptives will be recommend by 9.6% and 2.2% of users respectively.

ISSN: 0975-3583, 0976-2833 VOL 13, ISSUE 08, 2022

Table 4: According to respondents which method they will recommend to their friends or relatives (n=408)

Methods	Frequency	Percentage
OCP's	94	23.0%
Condom	108	26.5%
Female Sterilization	29	7.1%
Rhythm method	1	0.2%
Male Sterilization	7	1.7%
IUD's	39	9.6%
Injectable Contraceptives	9	2.2%
None	121	29.7%
Total	408	100%

Majority of the respondents in the study area showed no preference for any gender (80.1%), it was followed by 13.5% of the respondents who showed their preference for male gender, as expected lowest percentage of respondents who showed preference for the girl child were 6.4%.

Table 5: Distribution of participants according to preference for child gender (n=408)

		Number	%
Gender preference of the child	Girl	26	6.4%
	Boy	55	13.5%
	None	327	80.1%
	Total	408	100%

DISCUSSION

Because of existence of strong correlation of local socio-cultural characteristics with contraceptive use and its awareness, an attempt was made to study the role of various socio-demographic factors associated with awareness and use of contraceptives.

In the present study, the distribution of participants differ according to the defined age groups, most of the respondents lie in the age group of 24-29 (54.41%), followed by 30-35(31.61%), and the least number of respondents were of age more than 35. According to SRS report India 2014, 64.4 % of women lie in the age group of 15-59 [4], and in terms of Uttar Pradesh 70.7% of women were married. [5]

In terms of educational status, maximum numbers of respondents were illiterate (38.97%) and minimum were intermediate pass (1.96%).Same trend follows in the educational status of husband of respondents i.e. maximum respondents were illiterate (26.0%) and minimum were intermediate (10.5%).

In the current study majority of the respondents were housewives (85.53%), rest were rather divided equally in other occupational groups. In terms of income maximum respondents (81.36%) have income less than Rs. 10000.

Religion wise Hindus constitute the majority (71.07%) followed by Muslims (25.98%). Regarding family size and type maximum respondents were from joint family type and having family size of 5-8 members.

It was observed in the study that respondents have knowledge regarding majority of contraceptives to a larger or lesser extent. This knowledge is synchronous to education level, age of respondents, family type etc.

In the study it is evident that attitude of respondents towards contraceptives is generally favorable with 76.5% respondents denied any side effects associated with them. Moreover

ISSN: 0975-3583, 0976-2833 VOL 13, ISSUE 08, 2022

91.4% of the participants asserted that there are no associated social and cultural problems during contraceptive usage. The results are quite similar to Ranjan.S ,Kaur. S[6] in which the study revealed that 77.3 percent did not have any complain whereas i.e. 22.7 percent developed minor side effects with temporary contraceptive usage. The findings were congruent with the findings of a study conducted by Das NP et al[7] in the slum of Baroda which revealed that the 80 percent of women did not have any side effects with the use of contraceptive method.

It was evident in the study that majority of the respondents in the study area showed no preference for any gender (80.1%), it was followed by 13.5% of the respondents who showed their preference for male gender, as expected lowest percentage of respondents who showed preference for the girl child were 6.4%. Khandelwal.V et al[8] found that among study subjects most preferred gender composition was equal number of boy & girls as considered by 64.5% of women.

There will be a need to address the issues that are present with users for their unawareness, and why they do not want to use contraceptives, it may be because of lack of awareness or wrong attitude or psychosocial stress.

CONCLUSION

Inspite of having good knowledge about family planning methods & positive attitude there are some factors like desire for large family, pressure from husband, religious concern etc. lead to non-use of contraceptives. So this is important to improve educational status of the female to overcome these barriers and increase the uptake of modern contraceptive methods.

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