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KNOWLEDGE, ASSESSMENT AND PRACTICE OF USE OF CONTRACEPTIVES IN MARRIED FEMALE POPULATION IN CENTRAL MAHARASHTRA

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INTRODUCTION

In 2005, there were more adults and children living with HIV, more new HIV infections, and more AIDS-related deaths in sub-Saharan Africa than in any other region of the world.[1] Of the estimated 2.3 million children living with HIV worldwide at the end of 2005,[2] million (nearly 90%) were living in sub-Saharan Africa, along with more than 12 million orphans on the continent.[1] These high levels of HIV prevalence exist in countries that also often have high levels of fertility and low contraceptive use. Comprehensive HIV/AIDS prevention programs must also address the prevention of unplanned pregnancies among couples living with HIV, while also providing couples with services and support to manage their fertility desires. There is a lack of systematic research on family size preferences and contraceptive use among HIV-positive women in Africa, and although many studies have examined the determinants of contraceptive adoption in African countries,[4] few studies have examined the intersection between HIV and contraceptive use. Studies on the fertility preferences of HIV-positive women in the United States have shown poor family planning uptake; however, women in these cohorts were often intravenous drug users and are in many ways not comparable to African women.[3] Acceptance of contraception among HIV-positive African women may well depend on a number of social, cultural and economic factors, and the mechanisms through which family planning and VCT services are integrated and delivered. Previous studies show that despite initial uptake of contraception after counseling, contraceptive use among HIV-positive women often declines with time, as pre-sero-conversion fertility desires return in the context of an environment of low contraceptive use and cultural constructs that support high fertility.[5,6] Thus, although some attention has been paid to the contraceptive needs of HIV-positive women,[7,8] and to the influence of knowledge of sero-status on contraceptive use,[9] there is a lack of information on the knowledge and concerns surrounding family planning among those living with HIV. Birth control, also known as contraception and fertility control, is a method or device used to prevent pregnancy.[1] Birth control has been used since ancient times, but effective and safe methods of birth control only became available in the 20th century.[2] Planning, making available, and using birth control is called family planning.[3][4] Some cultures limit or discourage access to birth control because they consider it to be morally, religiously, or politically undesirable.[2] The most effective methods of birth control are sterilization by means of vasectomy in males and tubal ligation in females, intrauterine devices (IUDs), and implantable birth control.[5] This is followed by a number of hormone-based methods including oral pills, patches, vaginal rings, and injections.[5] Less effective methods include physical barrierssuch as condoms, diaphragms and birth control sponges and fertility awareness methods.[5] The least effective methods are spermicides and withdrawal by the male before ejaculation.[5] Sterilization, while highly effective, is not usually reversible; all other methods are reversible, most immediately upon stopping them.[5] Safe sex practices, such as with the use of male or female condoms, can also help prevent sexually transmitted infections.[6] Other methods of birth control do not protect against sexually transmitted diseases.[7] Emergency birth control can prevent pregnancy if taken within the 72 to 120 hours after unprotected sex.[8,9] Some argue not having sex as a form of birth control, but abstinence-only sex education may increase teenage pregnancies if offered without birth control education, due to non-compliance.[10,11] In teenagers, pregnancies are at greater risk of poor outcomes.[12] Comprehensive sex education and access to birth control decreases the rate of unwanted pregnancies in this age group.[12,13] While all forms of birth control can generally be used by young people,[14] long-acting reversible birth control such as implants, IUDs, or vaginal rings are more successful in reducing rates of teenage pregnancy.[13] After the delivery of a child, a woman who is not exclusively breastfeeding may become pregnant again after as few as four to six weeks.[14] Some methods of birth control can be started immediately following the birth, while others require a delay of up to six months.[14] In women who are breastfeeding, progestin-only methods are preferred over combined oral birth control pills.[14] In women who have reached menopause, it is recommended that birth control be continued for one year after the last period.[14]

KEYWORDS

1) Contraceptives methods,
2) Sexually Transmitted Diseases,
3) Pregnancy,
4) Married,
5) Central Maharashtra,
6) Preferences.

AIMS ANDOBJECTIVES

1) To assess awareness contraceptives in married

female population.

2) To know the knowledge regarding contraceptives in married female population.

MATERIALS AND METHODS

Study Design: Cross sectional study with the sole objective to gather relevant information pertaining to the research topic of interest.

Study type: Cross sectional Study.
Sample size: 100 (convenient sampling)
Study population: Married female population.
Selection criteria: Married female population.
Exclusion criteria: Unmarried female population, Male population of any age.
Study setting: Outpatient department (OPD) patients of Department of Obstetrics & Gynecology.
Instruments: No instruments was used.

Plan of analysis / Statistical tools- Expert statistical guidance was obtained to analyze the data gathered in this study.

Amendment of Protocol: No change in the study procedure was made.

Confidentiality: The identity of patient generated in the study was bounded in strict confidence. The data was available only to the investigator involved in the study and to the regulatory authorities. Break in the confidentiality was never done.

OBSERVATION AND RESULTS

Table 1:

Age Group.	Number
31-40	21
41-50	54
51-60	25

Table 2:

Methods	Out of 100
Vasectomy.	12
Tubectomy.	21
Copper-T	17
OCP	10
Condom.	40

Table 3:

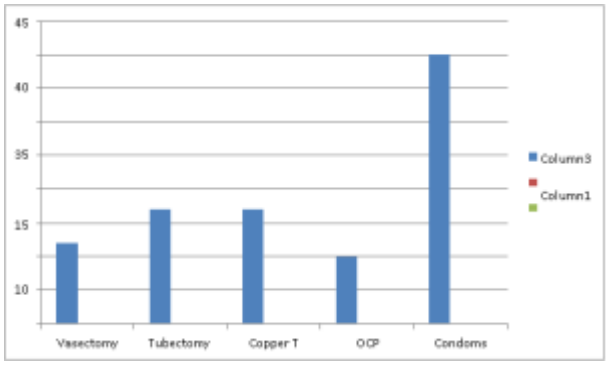
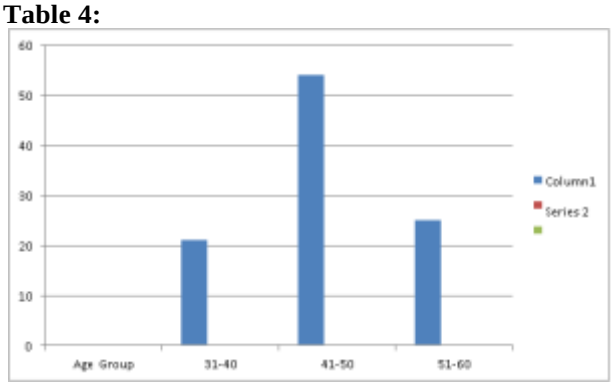


Table 4:



CONCLUSION AND DISCUSSION

This group of females are in utmost need of using contraceptive devices and also most receptive to family planning. According to National Family Health Survey 56% of ever married Indian women is using family planning. None of the female had complete basic knowledge regarding family planning methods. Also television was their chief source of information. Reddy et al in 2003 stated that the major source of knowledge about Family Planning methods for the study population was magazines followed by personal relations i.e. spouse, friends and relatives, mass media and health personnel. The role of health care providers in providing contraception knowledge should be emphasized as it's a two way communication process. Most of the female's attitude towards use of family planning method was satisfactory. But most of them said that they act according to their spouse or in law's decision. They have no choice related to child birth. Most of females were using Condom, adopted permanent method. Use of modern methods of contraception has increased in past few years. This reflects that couples are adaptive to newer and better methods of contraception.

As far as the age of respondents is concerned, our results coincide with the survey findings conducted in Chicago in 1971 that 70% of married women were in age between 20 to 39 years9. Similarly, a (KAP) study was conducted in India to assess "knowledge", "attitude" and "practice" of family planning, it also revealed that age of the married women (20-40) years10. Our results are also in line with Pakistan reproductive goals and family planning attitudes study, which showed that 75.4% married women were in age between 30 to 40 years.

The study conducted in Chicago in 1971 also showed that desire for the number of children differed significantly from the number of children produced. Some of results are in line with Pakistan reproductive goals and family attitude study, which showed that size of family and fertility outcome in cultures where men's rule in family, has much of importance in dimension of gender relations. Men and women could have similar fertility preferences; men want to have large families to get stronger economically and

socially powerful. While women may have high "fertility desires" for old age support. Some results also have close resemblance with the study findings done in Bangladesh, which revealed that couples involvement is a challenge for Bangladesh family planning program. Earlier study done in India showed the level of education, about 24% of the women was illiterate and 54% had their Matric10. The survey conducted in Pakistan about reproductive goals and family planning showed that husbands being more educated than wives, 49% husbands have similarity in educational level when compared to 17.5% of their wives. This is due to underprivileged position of women in "economic" and "decision-making" spheres. It inhibits them to make choices about their "family size" as well as "family planning". On the other hand, educated couples are more likely to use contraception.

Our results have similarity with a study done in rural central India, men there considered "family planning" associated with "female sterilization", and they saw "contraception" as to "spacing methods", with limited knowledge. Knowledge and current family planning methods use in Pakistan in 2000 and 2001 showed the use of pill (1.9%), knowledge about pills (76.5%), current use of condoms (5.5%), knowledge (57.6%), current use of injection (2.6%) and knowledge about injections (75.5%)14. Our results are further supported from a study done in Yemen in 2007 that 90% of women were aware of pills, intra-uterine devices and condoms. The survey results in Senegal showed that men and women know about methods such as the pill, intra-uterine device (IUD) and injections, as campaigns of family planning had focused on these methods. Global contraceptives prevalence is 63.4%19. In Pakistan, contraceptive prevalence rate (CPR) is 28%, which is not up to the desired level and discouraging as compared to CPR of neighbouring countries like India (48%), Bangladesh (58%) and in Srilanka (70%).

Regarding attitude, our results are in close resemblance to a study done in Yemen regarding attitude towards modern contraceptives methods. According to this study most of the respondents (89.3%) showed positive attitudes towards family planning and appreciated the effectiveness of modern methods than traditional methods. The majority of husbands (51.3%) agreed that husbands should also practice family planning. Some of the respondents were against family planning due to the religious beliefs that Islam is not in favour of contraception and its Allah will and we cannot interfere in Allah well. A study conducted in district Sindh, Pakistan, revealed that family planning programs are influenced by religious and cultural pressures. A study done in Jordan, showed that nearly 40% of married men were against practicing contraception and believed that family size should be left up to God.

Child birth is the leading cause of death among women of reproductive age as one in five women of reproductive age die due to child birth related complications. Realizing this fact, as well as considering other benefits, family planning program in the public sector of Pakistan was incorporated in 1960 but still the CPR of 30% is highly discouraging. In comparison, the CPR of neighbouring countries are quite high as 56% in Bangladesh and India while 68% in Srilanka. In spite of the fact that more than 3000 family planning centers are working in the country, population growth rate is still 1. According to Pakistan Demographic & Health Survey, maternal mortality can be reduced by 36% if CPR goes up to 55%. Despite almost 3 folds increase of contraceptive use since last 20 years, 25% of the currently married women have an unmet need of family planning services. Literacy rate in this study was very low.

Because our study was conducted in government hospital where usually poor people seek medical treatments who are mostly uneducated.

This study intended to deliver the knowledge, attitude, perception, and practices of family planning among married women. It was revealed that despite adequate knowledge about family planning among married women, use of these methods by present women was truncated. Adequate birth spacing and lower parity along with improved education levels and improved standard of living will help in minimizing mortality and morbidity related to family planning concerns among married women. Training should be given to reproductive health workers concerning the use of family planning methods.

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