Original Research Article

Contraceptive use and role of women in the decision among contraceptive acceptors

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Abstract

Background: Women play a crucial role in the welfare of family but they were not considered while making important family decisions. Now women are empowered with education and financial independence. This might have changed the scenario. A cross-sectional study was undertaken to find out the involvement of women either alone or jointly with the husband in decision of use of the contraceptives and deciding family size. **Materials and Methods:**385 mothers visiting an Immunization Centre of a teaching hospital were interviewed with the help of a pretested structured questionnaire. **Results:** Most of the women (96.6%) were aware of some contraceptive methods. 53.6% of couples had ever used contraception while 39.2% were currently using modern contraceptive methods. Only 11.9% of the couples used contraception to postpone their first pregnancy however the use of contraception increased as the expected gap between marriage and first pregnancy increased. As socioeconomic status and education level of women increased, the acceptance of contraceptives by couples increased significantly. Also, acceptance was more by couples from nuclear families and financially independent women. Women were involved in decision making of use of contraception by either partner in 92.2% of cases but her involvement in deciding family size was only 65.5% ($p<0.001$). Nuclear family and upper socioeconomic status of the family were associated with her involvement in the deciding family size however her education and financial independence were not associated. **Conclusion:** Better socioeconomic status, nuclear family pattern, education, and financial independence have enabled women to play an important role in decision making regarding family planning but her role is still limited when it comes to deciding the family size.

Key Words: contraception, socioeconomic status, pregnancy, decision making

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INTRODUCTION

India was the first country in the world to launch a National Family Planning Program in the year 1952. Inspite of having a nationwide program running for so many years the use of modern methods of contraception was only 54% during 2015-16(NFHS 4).[1] The problem of family planning is essentially the problem of social change. The World Conference of the International Women's Year in 1975 declared "the right of women to decide freely and responsibly on the number and spacing of their children and to have access to the information and means to enable them to exercise that right."[2] Although such a right is given to women in an international conference, it is culturally not practised in many developing countries including India. Indian culture being patriarchal, women may not be considered while taking any important family decisions including that of family planning.[3,4] Now many women are empowered with education and financial independence. It is shown that contraception acceptance is more with better education status, and financial independence.[5,6] Not only the use of contraception is important but the role of women in making the decision of family planning is also very important. Couples' joint decision-making is found to be a strong determinant of the use of contraceptive methods which was over and above the contribution of women's socio-demographic and economic statuses.[7] Not much is studied about the role of Indian women in the decision making of family planning. The present study was conducted to find the use of contraceptives by the couples and in those who used contraceptives ever, determine the role of women either alone or jointly with the husband in the decision of its use. The role of women wasalso assessed for deciding family size.

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MATERIALS AND METHODS

This hospital-based cross-sectional descriptive study was conducted at the Immunization Center of a tertiary care teaching hospital in Pune, Maharashtra. Mothers visiting the immunization center with their children were interviewed. The role of women in decision making of family planning, either alone or jointly with their husband was found to be 60.2% in Kolkata.[8] Considering this prevalence and the allowable error of 5%, the estimated sample size was 384. Therefore the study was conducted on 385 women who visited the immunization center. The data was collected using a predesigned pretested structured questionnaire, interviewing the mothers who brought their children for vaccination at the Immunization Center. A systematic random sampling technique was used to select women. Every fifth mother visiting the immunization center was approached and none of them refused participation in the study. Data was analyzed using the SPSS software 25.0 version. Results for quantitative variables were shown by descriptive statistics. For qualitative variables, frequency and percentages were calculated. A chi-square test was used to find the association between various demographic characteristics and contraceptive acceptance. The Z test between two proportions was used to find out the difference between the involvement of women in decision making for contraceptive use versus their involvement in decision making about family size. P value of < 0.05 is considered as significant.

RESULTS

The mean age of the participants was 25.3 (± 3.8) years with a range of 18 - 39 years. The interquartile range was 28-23 years. Age at marriage ranged from 13–33 years, with the mean of 20.5yrs (± 3.0) and interquartile range of 22-18yrs. Though the legal age of marriage is 18 yrs, 38(9.9%) women were married before the legal age of marriage.

Of the 385 women, 208 (54.0%) had only one child, 152 (39.5%) had two children, 24 (6.2%) had three children and only 1 woman (0.2%) had four children. Regarding knowledge about contraceptives, 372 (96.6%) women were aware of some of the contraceptive methods. Most of them had knowledge about Oral Contraceptive Pills (OCPs) (92.1%), Copper T (87.9%) and condom (85.0%). Of the 385 couples, 205 (53.2%) couples had used contraceptives at least once to date. This use was either by the wife, husband or both.

Table 1: Demographic Details of women from Contraceptive Acceptor and Non-Acceptor couples

	Contraceptive Acceptors (n=205)	Contraceptive Non- Acceptors (n=180)	Chi square value	P value
	No (%)	No (%)		
Women age in yrs				
18 - 23	48 (34.0)	93 (66.0)	33.32	<0.001
24 - 29	119 (63.3)	69 (36.7)		
30-35	34 (68.0)	16 (32.0)		
≥ 36	4 (66.7)	2 (33.3)		
Type of Family				
Joint	110 (48.0)	119 (52.0)	6.16	0.013
Nuclear	95 (60.9)	61 (39.1)		
Socioeconomic Status				
Class I	86 (61.0)	55 (39.0)	13.89	0.008
Class II	79 (54.1)	67 (45.9)		
Class III	30 (43.5)	39 (56.5)		
Class IV	8 (29.6)	19 (70.4)		
Class V	2 (100)	0 (0.0)		
Education				
Illiterate	4 (44.4)	5 (55.6)	21.30	0.001
Primary	5 (41.7)	7 (58.3)		
Secondary	74 (45.4)	89 (54.6)		
Higher Secondary	41 (47.1)	46 (52.9)		
Graduation	58 (69.0)	26 (31.0)		
Post-graduation	23 (76.7)	7 (23.3)		
Financial Independence				
Working	34 (68.0)	16	5.02	0.025
Non-working	171 (51.0)	164		

Table 2: User of Contraceptives

	For postpone 1st pregnancy n=385	For keeping gap between 2 children n=385	Sterilization n=385
User	No (%)	No (%)	No (%)
Husband	34 (8.8)	70 (18.2)	1 (0.3)
Wife	9 (2.3)	65 (16.9)	43 (11.2)
Both	3 (0.8)	28 (7.3)	0 (0)
Not used	339 (88.1)	222 (57.6)	341 (88.6)

Table 3: Decision maker for use of contraceptives And Family size

Decision Making use of family planning	Wife ,n(%)	Husband,n (%)	Wife Jointly with Husband,n(%)	Other,n (%)	Total,n (%)	Womensinvolment in decision,n(%)	Z-test value	p-value
A: Contraception use for postponing 1st Pregnancy	2(4.1)	3(6.1)	44(89.1)	0(0.00)	49	262 (92.2)	**0.27**	**<0.001**
B: Contraception use for spacing between two children	11 (5.8)	11 (5.8)	167 (87.4)	2 (1.00)	191			
C: Sterilization	2(4.5)	3(6.8)	36(81.0)	3(6.8)	44			
Total	15 (5.3)	17 (6.0)	247 (87.0)	5 (1.8)	284 (100.0)			
Family Size	20 (5.2)	39 (10.1)	232 (60.3)	94 (24.4)	385 (100.0)	252 (65.5)		

Table 1 gives demographic details of the women from contraceptive acceptor and non-acceptor couples. Only 34.0% of women from the very young age group of 18-23 years were contraception acceptors whereas 66-68% of women from 30 years onwards had used contraception at least once. Advancing age was associated with contraception acceptance ($p<0.001$). Of the 385 women, 229 (59.5%) were from joint family. Most of the women were from upper socioeconomic status, 37.9% from class I and 36.6% from class II. Very few i.e. 9 (2.3%) women were illiterate however 42.3% had done secondary level education. 114 (29.6 %) women had at least completed their graduation. Contraceptive acceptance was more in working women than non working but the difference is not significant. The acceptance of contraceptives was more for couples from nuclear families. The use of contraceptives increased as the socioeconomic status improved. Similarly, the acceptance of contraceptives increased with an increased level of graduation and financial independence of women. Out of 151 women who told that expected the gap between marriage and pregnancy should be of 1 yr, only 11 couples (7.3%) had used contraception to postpone the pregnancy. Out of 182 (47.3%) women who told that the gap should be of two years, only 23 couples (12.2%) had used contraception whereas out of 36 women who expected a gap of three years, 6 couples (16.7%) used the contraception to postpone the first pregnancy. The use of contraception was maximum in the couples where the expected gap was > 3 years i.e. 6 couples (37.5%) out of 16 used contraception. The use of contraception increased as the expected gap between the marriage and first pregnancy increased ($p = 0.003$). Almost 50% of women expressed that the expected gap between two children should be ≥ 4 years and 36.8% expected a gap of 3 years. When asked about the ideal person from the couple who should use contraceptives to keep a gap between two children, 143 (37.1%) women felt that the husband should use contraception. 130 (33.8%) women felt that the wife should use contraceptives while 101 women (26.2%) felt that husband and wife both should use contraceptives. 11 women (2.9%) did not answer. Table 2 gives details of the actual user of contraceptives. Only 46 (11.9%) couples used contraception to postpone their first pregnancy where most of the time it was the husband who used contraceptives compared to wife. However, the use of contraceptives by wife increased for keeping a gap between two children. At the time of study,147 (38.2%) couples were using either temporary (103, 26.8%) or permanent (44, 11.4%) family planning methods. In temporary contraceptives methods, 42.8% were using condoms, 11.2% of women had inserted Cu T and 9.8% were using OCPs. For those couples who used contraceptives at various stages i.e. to postpone first pregnancy or to maintain a gap between two pregnancies, most of the times, the decision was taken jointly by the husband and wife. Table 3shows the decision-maker for the use of contraceptives by the couple and for deciding the family size. Women's involvement either alone or with husbands in the decision of use of the contraceptive by the couple was 92.2% however this involvement was only 65.5% ($p<0.001$) while deciding the family size. Decision regarding family size were taken by the husband or by the elders in the family-like mother in law or father in law. Women from nuclear families were involved more in decision making of family size than from joint family (83.3% Vs 53.3%, Chi square value = 37.07, $p<0.001$).

Women from upper socioeconomic classes were involved more than the lower class ($p < 0.001$). However, women's education and financial independence were not related to their involvement in deciding family size.

DISCUSSION

In this study, most of the women (96.6%) were aware of contraceptives however the contraception acceptance for modern methods any time in life and currently was only 53.2% and 39.2% respectively. It was similar to the study conducted in Uttarakhand i.e. ever used FP 58.4% and current users were 43.0%)[9] but studies have shown that women have knowledge about contraceptives but this should be transformed into practice. The woman if empowered with decision making power, alone or jointly with husband may turn this into practice.[1] In the USA women are being involved in general health care decisions but desire more autonomy in their contraceptive decisions.[11]But the situation in South Asia is different from the USA. Women are not involved in decisions of women's health care in Nepal, Bangladesh, and India.[12] Only 13.4% of married women in the reproductive age group from Nepal, 17.6% from Bangladesh and 28.1% from India could take decisions for their own health alone. Women were not involved in decision making in the majority of cases in Nepal (72.2%), which was comparatively better for Bangladesh (53.3%) and India (48.5%). However, in Nepal, the decision of use of contraception was taken jointly by the husband and wife in 80% of contraceptive users and decision was taken alone only by 11.5% of women. In the present study, contraception acceptance is more in nuclear families, in upper socioeconomic status, educated women and those who are financially independent which is similar to other studies.[6,13]Also it was associated with advancing age which may be because of more opportunities for using contraception with advancing age. However, the current use of contraceptives was low in this study. This may be because this study was conducted at the immunization center where few of the mothers were recently delivered and a few were staying at mothers' homes after delivery. Many women still feel that they don't need to use any contraceptives until they have lactational amenorrhea. A similar study conducted at an immunization clinic at Kolkata revealed that 48% of the couple were current users of modern methods of contraception. and almost 12% of women were using lactational amenorrhea as a natural method of contraception.[14] In this study, very few women could take the decision of use of contraception alone at all three stages i.e. after marriage to postpone first pregnancy (4.1%), to maintain a gap between two pregnancies (5.8%) and finally doing sterilization (4.5%). However, most of the times her decision for use of contraception was considered by the husband and both of them jointly took the decision which ranged from 81% to 89%. The findings were partially similar to the study conducted in West Bengalby Mundle M *et al.*[8] where only 5% of women took the decision of family planning alone while the joint decision was taken by 55.2% of couples. In 1/3rd cases, males were the sole decision-makers, whereas in another study, males were the decision-makers in 71.8% of the cases.[9] Our neighbouring country Pakistan has reported thata couple's joint decision of use of contraception is a stronger determinant of its use·7 Women's higher decision making power was associated with increased age, higher literacy and living in superior socioeconomic status. However, decision making was not associated with age, occupation, and education in the study conducted in Ethiopia.[15] Osuafor GN *et al.* reported that in Mahikeng from South Africa, in modern contraceptive users, 21% of women could take the decision on their own for use of contraception and 45% were the joint decisions.[16] Women who had done only primary education, the decision was mostly taken by the husband. Her involvement in decisions improved with education. When asked about decision-makers for family size, women's involvement was low (65.5%) compared to the decision for the use of contraception ($p<0.001$). Even husbands alone were not in a position to take the decision. These decisions are influenced by the elder ones in the house like mother in law or father in law. Significant women involvement was seen from nuclear families and from those from upper socio-economic status however it was not associated with women's education and financial independence. This tells that it's not a woman's individual status as education or financial independence but the status of the family as nuclear one or upper socio-economic conditions which are important to decide the number of children. There are various factors which decide the family size. Women's desire for ideal family size may be different from the husband or the rest of the family. If the husband expects a smaller ideal children number, it's possible to have a smaller family size independent of women empowerment.[17] Socio-economic status of family, the existing number of children, male preference etc. are a few of the deciding factors. Families with lower socio-economic condition may seek for more number of children which eventually would support the family in income generation. Also, the presence of a son is an important factor in deciding the use of contraception and the family size.[18,19]So for maintaining small family norm in the country, only women empowerment may not be sufficient.

Steps should be taken to overall improvement of socio-economic status of the society and negating the gender preference will help in limiting the family size. The study was conducted at an immunization center of a teaching hospital so may not represent the community. Also, the study involved women's perspective on family planning and family size which may be different from her husband.

CONCLUSION

In spite of having knowledge about contraceptives by most of the women, its use was limited. The use of contraception was more in the women empowered with education and financial independence. Overall women involvement in decision of use of contraception at various stages was good however her involvement in deciding family size was limited. The empowerment factors of education and financial independence were not associated with her involvement in deciding family size.

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