

We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

4,800

Open access books available

122,000

International authors and editors

135M

Downloads

Our authors are among the

154

Countries delivered to

TOP 1%

most cited scientists

12.2%

Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.

For more information visit www.intechopen.com



Factors Affecting the Attitudes of Women toward Family Planning

Nazli Sensoy, Yasemin Korkut, Selcuk Akturan,
Mehmet Yilmaz, Canan Tuz and Bilge Tuncel

Additional information is available at the end of the chapter

<http://dx.doi.org/10.5772/intechopen.73255>

Abstract

Everyone has the right to decide on the number and timing of children without discrimination, violence and oppression, to have the necessary information and facilities for it, to access sexual and reproductive health services at the highest standard. Deficient or incorrect family planning methods, wrong attitudes and behaviors toward the methods and consequent unplanned pregnancies, increased maternal and infant mortality rates are the main health problems in most countries. Individuals' learning modern family planning methods and having positive attitude for these methods may increase the usage of these methods and contributes the formation of healthy communities. It is considered important to examine the current attitudes and determinants in order to spread the choice of effective method.

Keywords: women, attitudes, family planning, reproductive health

1. Introduction

Everyone has the right to decide on the number and timing of children without discrimination, violence and oppression, to have the necessary information and facilities for it, to access sexual and reproductive health services at the highest standard [1]. Deficient or incorrect family planning methods, wrong attitudes and behaviors toward the methods and consequent unplanned pregnancies, increased maternal and infant mortality rates are the main health problems in most countries.

Individuals' learning modern family planning methods and having positive attitude for these methods may increase the usage of these methods and contributes the formation of healthy communities [2]. More than 22 million unsafe abortions that occur every year cause about

47,000 maternal deaths in the short or long term, mostly in developing countries [3]. It is estimated that up to one-third of maternal deaths can be prevented by using contraception in women who are seeking to postpone or delay postpartum [4].

Across the world, it is estimated that 222 million women have unmet need for family planning [5]. This unmet need prevalent in particular populations, especially those who are sexually active, those with low socioeconomic status, those living in rural communities and those coping with conflicts and disasters [6].

Increasing usage of contraceptives in some developing countries has reduced the annual number of maternal deaths by 40% in the last 20 years and has reduced the maternal mortality rate (the number of maternal deaths in 100,000 live births) by 26% in recent years. If the need for uncontrolled birth is met, it is estimated that maternal mortality still occurring in these countries can be avoided by more than 30% [7]. The 'Family Planning 2020' initiative was started at the London Family Planning Summit in July 2012. The main objective of this initiative is to provide contraceptive information, services and supplies for 120 million women and girls until 2020 [8].

2. Family planning

Family planning is defined as having the freedom and responsibility of all the couples and the individuals to decide the number of children they desire and having the knowledge, education and tools for this purpose. In other words, family planning is a preventive service that allows married couples achieving their desired number of children and deciding the spacing of pregnancies according to their economic opportunities and personal wishes, and to ensure that the births are at appropriate intervals for the mother and child health.

Family planning does not mean limiting the number of people in a family. The goal of family planning is preventing pregnancy-related health risks in women and reducing the need for unsafe abortion and infant mortality (see **Table 1**). Maternal health, risk of pregnancy and even maternal death significantly increase when births made at intervals of less than 2 years. In addition, babies born at frequent intervals are not fully developed (babies with low birth weight), disability rate increases, care becomes difficult and infant mortality increases in the mother's womb.

Family planning can result in higher levels of education, better employment opportunities, higher socioeconomic status and empowerment. Another aim of family planning services is to prevent unwanted pregnancies and related maternal and infant mortalities, to provide help and counseling to every family whenever they want and to have as many children as they want. Family planning services improve the abilities of family members in decision-making and recognize the freedom to make free decision about having a child. Family planning services have an important role within the scope of "Primary Health Care", which must be presented to the public [9–11].

In studies on family planning in the world, differentiation in attitudes, behaviors and the use of contraceptive methods largely lead to change in fertility [4]. Biological, psychosocial,

-
- To educate individuals and families about reproductive health
 - To raise the level of maternal and child health by teaching modern and medical ways of protecting the parents from pregnancy
 - Many and frequent births have negative effects on mother and child health
 - Preventing maternal deaths and protecting their health
 - To ensure that babies are born and live well
 - To prevent high-risk and unwanted pregnancies
 - Providing medical assistance to those who want to have children and educating individuals about family planning methods.
-

Table 1. The purposes of family planning.

cultural factors determining fertility and factors affecting choice and use with birth control instrument are evaluated together in the regulation of fertility [12].

3. Unmet need for family planning

Unmet need for family planning is a concept that has come to the agenda in recent years. Unmet need for family planning refers to women who have the ability to give birth before they have another child (want to increase the interval of births) or who do not want to have any other children (want to terminate their fertility) but do not use any contraceptive methods.

In developing countries, there is a significant gap between women's reproductive preferences and the use of contraception. This inconsistency is called an 'unmet need' for family planning [13]. At least 1 in 10 married or in-union women in most regions of the world has an unmet need for family planning. Worldwide, approximately 12% of married or in-union women are estimated to have an unmet need for family planning; that is, they wanted to stop or delay childbearing but were not using any method of contraception.

In general, unmet need is high where contraceptive prevalence is low. The lowest level of contraceptive prevalence in Asia were in Afghanistan and Timor-Leste at 29%. In 59 countries, at least 1 in 5 women on average had an unmet need for family planning in 2015, and 34 of these 59 countries are in Eastern Africa, Middle Africa or Western Africa [14]. In Turkey, the unmet family planning requirement is 6% [15].

Unmet need for contraception and unwanted pregnancy is a major public health problem in most countries. However, the relationship between unmet need for contraception and unwanted pregnancy has not been studied adequately. Bishwajit et al. investigated that the prevalence of unmet need was 13.5%, and about 30% of these women expressed their unwanted birth of their last pregnancy in Bangladesh [16].

An important way to remove unmet needs for family planning is to increase the diversity of contraceptive methods. Individual choosing the contraceptive methods may change depending on their individual needs and family character differences [17]. Also, women refusing to

use contraceptives and without desire to prevent pregnancy are responsible for about 38% of women with unmet needs.

Giving expanded alternatives to different methods, if available, can help to meet some of their needs and increase their usage of contraceptives. Extension of accessibility for different method can reduce contraceptive discontinuation by 8%. Beside this, wider range of options may cause some of women (62%) who have unmet needs to become users [18]. For example, an increase in the availability of a new method may increase the contraceptive prevalence by 8 points [19]. Finally, some users will need contraception to protect against sexually transmitted infections such as human immunodeficiency virus [20].

There are very few studies comparing outcomes among women who have unmet need, depending on whether they are planning for future contraceptive use or not. Analysis of Cross-sectional Demographic and Health Sector (DHS) data reported that 26–83% of women who were unmet need in 48 countries thought to use any contraceptive [21]. Additionally, DHS data show that participants were considered to have unmet needs regardless of their attitudes toward their next pregnancy who indicated that they were pregnant or amenorrheic and wanted this pregnancy or had their last pregnancy. However, most of these women do not desire to get pregnant again in a short span of time, and say that they are willing to use contraceptives. Ross and Winfrey indicate that 40% of postpartum women in 27 countries are intend to use a method within the next year [22].

Between 2006 and 2009, 32% of 2853 women who were married during the survey period between the ages of 13 and 49, got pregnant at least once. Women with or without unmet need in these pregnancies were significantly more equally divided in terms of contraception (30 and 33%). All pregnancies among women who have unmet need are considered unwanted. However, 40% of unmet need pregnancies were among those who said they did not want more children; this result was interpreted as those women changed their childbearing intentions, stopped using the method or were exposed to contraceptive failure [23].

4. Attitudes affecting family planning

Attitude refers to the positive or negative feelings or tendencies of an individual about an idea, an object or a symbol. According to Bohner, the attitude is anything that a person actually possesses and that he realizes later. According to Arkonaç, attitude, generally attributed to many academicians, is a tendency which is attributed to a person and which creates his feelings and behaviors related to a psychological object in an orderly way. Attitudes naturally affect beliefs as well. Faith includes true or false information, opinions and beliefs based on personal experimentation or external sources. All variables affecting family planning cause behavior to occur [24, 25].

Behaviors and attitudes play an important role among the choice of using family planning methods and so it effects the change of fertility status and population rate indirectly. In order to promote the usage of an effective method, attitudes and behaviors play an important role on preference of choosing a family planning method. The identification of attitudes that affect the use of the family planning method by individuals is an important factor contributing to the scheduling of family planning services [26–28].

The basis of most attitudes depends on childhood and is generally acquired through direct experience, reinforcement, imitation and social learning. The most important feature is that once they have developed, they are very resistant to change [29]. Studies conducted in different countries have found that most women know the methods of family planning but have a lack of practice. This is due to the fact that individuals are in a negative and prejudiced attitude toward modern methods. It is known that positive or negative attitude affects the use of family planning method. It is considered important to examine the current attitudes and determinants in order to spread the choice of effective method [26–28].

Individuals obtain information about family planning methods, emotionally empower them with information and ultimately turn their attitudes toward information into positive or negative behavior. Individuals also respond to the reactions they have through the process of transformation into behavior [2].

Individuals' attitudes for family planning methods are influenced by some characteristics, such as economic factors, sociocultural factors, environmental factors, location, age, educational, traditional beliefs, religion, family type and level of knowledge. It is known that these factors have effects on turning the attitudes into behaviors. Attitude is a notional concept and although it cannot be observed directly, the effects on behavior are well known [30, 31].

Individuals get the knowledge of family planning methods, then they transcribe it emotionally by themselves. After all they combine them with their attitudes and positive or negative behavior is ready for decision of which method is suitable for them [32].

Many anthropologists have insisted that reproductive behavior or decisions made in relation to family planning is not only decided by economic factors, but also affected by sociocultural factors such as fertility preferences or values related to having children. Further, political issues such as national population policy or reproductive health programs, are also influential matters. Subsequently, anthropologists emphasize that it is very important to understand what social, cultural or structural factors may shape peoples thoughts and behaviors [33].

In early 1970s, two factors were found to affect the fertility behavior of women. Surveys on sex preferences have used deductions from attitude and behavior charts due to inadequate direct scales. In this regard it is possible to distinguish three groups of countries: countries where it is reasonable to choose male siblings; male siblings are preferred due to certain criteria; and countries with no sexual preference systematically. There is a period during which the transition from high fertility to low fertility requires couples to decrease the number of family members but yet not practitioners of contraception. Those who do not use any contraception methods, among those at any age, who want to limit their family size are far more numerous than those in developed societies compared to the developing societies. When education is considered as one of the variables of modernization, it is understood that inconsistent behavior tends to decrease with education [34].

By 1980s, comparable data for a large number of developing countries participating in the World Fertility Survey (WFS) have become available. Cross-national studies based on WFS data confirmed that education generally exerts a negative influence on fertility. But even at low levels of socioeconomic development, where education had a negligible, a negative association emerged after a critical level of schooling, was reached [35]. A pronounced preference of parents to have male children has been noted in a number of countries, although a desire of a balanced number of sons and daughters is also common [12].

In recent years, the idea that it is significant to understand the sociocultural contexts in demographic studies has gradually expanded [33]. Some studies have mentioned the importance of the role of men in reproductive health and their influence on decision-making and behavior related to reproduction [36, 37]. As mentioned above, many family planning programs have focused mainly on women. Even though men are increasingly being “involved” in reproductive health programs, the view of men still seem to be that they are peripheral and problematic [36].

4.1. Socioeconomic factors

Gender indicates the characteristics, positions and roles of man and woman in all social relationships. But in most studies on family planning, women are usually on the front line of factors that affect socioeconomic outcomes. For age, a commitment to supporting gender equality in economic outcomes has underlined women’s empowerment.

However, despite important advances toward equality, differences in the socioeconomic outcomes of men and women still persist. If the population is increasing by forcing natural resources and economic opportunity, the necessity of implementing effective and adequate family planning in the society is emerging. With industrialization, families have better economic opportunities and social security. Thus, aggravating living conditions and taking more roles in women’s work life reduces the desire to have many children.

It is accepted by many scientist upon that human rights are an integral part of the economic process, and that it is impossible to support that process without women. Consequently, it is necessary to expand the aims of existing societies to include the interests of women.

Everywhere in the world, men have an important role in the socioeconomic progress of women. When designing social sex-based policies, ignoring women increases both their effectiveness and inequality. The use of fertility and contraception in developing countries are associated with socioeconomic status and other relevant factors [38].

The withdrawal method is the most commonly used birth control method in the world. There are not enough data on whether withdrawal method choice is influenced by variables such as socioeconomic status and education [39]. It was demonstrated that withdrawal use is quite common among young US females in different study. Because nearly one-third of females aged 15–24 years in study nationally representative sample indicated that they had recently used withdrawal [40].

4.2. Sociocultural factors

In every cultural group events such as coitus, pregnancy and birth show differences. In a society, appropriate conditions for fertility and bringing the child to the world, pregnancy, how birth will be, what the prenatal and postnatal care standards are, the ‘birth culture’ that is peculiar to the collective and tries to preserve the basic approaches, perhaps changing a little from generation to generation and taught to other generations.

Economic conditions of the society (distribution of income, employment opportunities, etc.), family structure (which is common among the core/extended family models, relationships

among family members, sharing of responsibilities, etc.), gender roles, beliefs of society, marriage models (polygamy, same place, same family marriage, relatives marriage, etc.), sexual behaviors (premarital, out-of-marriage relationships, marriage prohibitions, etc.), using or not using contraceptive methods vary from community to community [41]. Properties of family, economic circumstance of community, the ban of some contraceptive methods in that society, opinion about abortus, concerns about using several contraceptive methods, population policies, gravidity, religion, the idea of sin, traditional practices, etc.; all of which are among the most important factors determining health status. Some are not direct health care determinants but may be preparatory, adjuvant or preventative [41].

Having a strong religious identity affects willingness of women to discuss contraception with their partners/families/communities and an unwillingness to consider accessing it and eventually using it. Similarly, the institutionalized religious doctrines intersect with cultural beliefs in a society which bestows man as the overall head of the house and, such beliefs are inherently subsumed in a patriarchal structure, where women have been relegated as a weaker gender and could only measure their freedom of choice within the acceptable framework.

4.3. Location

There are large differences by region. Contraceptives are used by almost all of the world's married or majority members. In 2015, 64% of married or in-union women between 15 and 49 years of age in the world were using any form of contraception. However, the use of contraceptives was much lower in less developed countries (40%), and was especially low in Africa (33%). Among other large geographical regions, the use of contraceptives increased significantly in 2015 from 59% in Oceania to 75% in North America [14].

Furthermore, place of residence has an impact on the use of contraceptive, and is higher in urban areas than in rural areas [42, 43]. The factors revealing these differences are better availability of social services such as education, access to health services, information and family planning services [44]. The results of a study support that social factors such as place of residence, affect the contraceptive utilization patterns.

In this study, urban women were found more likely to use contraceptives compared to rural women [44]. Another study showed that utilization of family planning methods was found more in women of age group 30 or more, parity four and more, educational level up to high school and above and those of higher socioeconomic status whereas their residential area (urban or rural) was not found an influencing factor on practice of family planning by them. This study showed that all the women, both in urban and rural area, were willing to adopt a family planning method in future. All the women interviewed were in favor of practicing family planning. However, only 55.9% women were found to have used some form of family planning. When comparing modern and traditional methods, the difference between the preferences of future family planning methods between urban and rural areas is statistically significant. Conservative use of the condom in rural areas (44.6%) and modern methods in urban areas (32.3%) seem to be at the highest level of future use preferences. The study also revealed a good knowledge and favorable attitude toward future use of family planning methods [45].

4.4. Age

The age of women plays an important role in the process of deciding when women will start and finish the process of giving birth and how long to wait after the birth of the next child. Also the use of family planning method varies according to the age of the woman. As women get older, their need for contraception and the rate of contraception decreases [45, 46].

In a study, it was demonstrated that younger women, often have a stronger fertility desire than older women. In this study, 26% of the women aged 15–24 wanted another child within 2 years compared to 16% among women aged 25–34 [47]. The use of pills and condoms are preferred more when the average age is lower. When the contraceptive use of married and fertile women is examined according to their age, it is observed that middle-aged women tend to use the family planning method more than younger and older ones [48]. Another study, demonstrated that use of contraception was maximum (84.8%) in 30 years and more and minimum (2.2%) in 20 years age [45]. Similarly NFHS-III, India reported more use of contraceptive by women of higher age group and parity [49].

Maternal age at first birth is an important determinant of the quality of life of the woman and the baby, maternal and child health and general fertility level.

4.5. Education

Women's education has a great influence on many health indicators and is one of the most commonly studied determinants of the use of contraception and unmet need. Women's attitudes toward family planning are influenced by experiences such as education and pregnancy. It was found that women who had a primary school graduate or higher education, had 1–3 pregnancies and did not want more children in the future got higher scores on the family planning attitude scale. As the level of education increases, the number of children required decreases [50]. The reason for this can be explained by the opportunity to learn about family planning and to raise awareness about the issue.

Similarly, as women's education levels increase, awareness increases. Sociocultural characteristics play an important role in this issue [51]. Education contributes significantly to the quality of women's lives. Improving women's access to education and encouraging continuous and constant exposure would significantly increase use of family planning and reduce unmet need.

In societies with high levels of education and socioeconomic status, marriage, pregnancy and childbearing age occur at a later stage and therefore the need for contraceptive methods increases. Using contraceptive methods prevent advanced pregnancies and high fertility. As the interval between births increases, the number of high-risk pregnancies decreases and maternal mortality declines. It was identified that the use of effective modern methods, intra-uterine devices and oral contraceptives, increased as the education level and socioeconomic status of the women improved.

Failure rate of contraceptive methods is reduced by informing pairs. Visual and audiovisual media play an important role in information provision and in creating awareness. Education and counseling services are most accessible and suitable for prenatal and postnatal periods [52].

4.6. Gender

Reproduction is a dual commitment, but in most of the world it is often seen as the responsibility of women entirely, and many family planning programs have focused mainly on women. Men are often described as forgotten reproductive health clients in family planning services.

The role of men in family planning population planners have received more interest in recent years as they begin to notice the importance of male influence on reproductive decisions around the world. Up to this point, many activities are in the effort to determine or develop the knowledge and attitudes of men about family planning. While men play a direct and major role in deciding contraceptives, they play an indirect role as a dominant factor in women's economic, social and family needs. The role of men in decision-making on women's fertility and birth is always dominant.

The United State Agency for International Development has addressed women's participation in many aspects of family planning, such as condom promotion through social marketing or community-based distributors, training and promotion of vasectomy and Information and Education Campaigns to increase awareness and knowledge and to influence behavior change. The prevalence of contraceptive method use in married men was found to be approximately 15.0%, about 6.0% in their wives and 16.0% in couples. The mean age of participants was 38.3 ± 9.0 and the respondents' spouses were 32.7 ± 8.4 . The percentage of married men who do not know how to read and write is 52.0 and 77.5% of their spouses are illiterate. Most married men were now using condoms and their wives were now using oral pills. Most married men (97.0%) were aware of common contraceptive methods. The research findings showed that married men who are illiterate and younger do not exchange ideas or allow their spouses to do family planning and that they do not even discuss family planning with their wives [53–55].

In another study, among married men about their contraceptive use and fertility preference reported interesting findings concerning male involvement in family planning decisions. The report also revealed that majority of the men have supportive attitude toward contraception use and recommended to strengthen efforts to convert the positive attitudes to positive behaviors to achieve greater success in family planning programs [56].

The reasons for inclusion of men in reproductive health issues are multifaceted. Above all, men have their own reproductive health concerns and their involvement should not be seen as a tool for better female reproductive health. Also, men's sexual health and reproductive health welfare and behavior directly affect their partners. Besides decisions about reproductive health occur in relationships between men and women [57].

Male methods of contraception, such as coitus interruptus and condoms, although they have historically played a far greater role than women's methods, are denigrated as being unreliable or associated with extramarital sex, respectively. Birth control pills have been put in place of birth control, but responsibility should be shared by partners regardless of pregnancy, no matters which of them desires. The prominence of behavioral factors is due to the fact that most of the contraceptive failures originate from human error [58].

In the private arena, men can directly influence women's economic and social progress. In many societies men still say the last words about family planning and reproductive health,

the use of family resources, including spouses and girls' participation in the labor market, and medical and educational spending.

In developed countries, men have limited participation in child care and domestic affairs; this situation places a great burden on women's education and professional life. The role of men in developing countries is even more important in patriarchal structures that supervise the health decisions of women of their husbands or other family members. Women's reproductive health is influenced by men's policy makers, male health care providers and men's services. Men also affect women's reproductive health as partners and ancestors.

Accordingly, understanding the behaviors and beliefs of the man about fertility and family planning is very important for the design of successful reproductive health policies. Poor knowledge of reproductive health issues among males may pose barriers for women to seek care for these problems [59].

Men as the heads of government and ministers of state, design and implement policies as leaders of religious and faith-based institutions, judges, chiefs of armies and other power organs. But they do not support women's priorities and needs. As public authorities, they also exercise control over a wide range of resources, such as health, education, transport or finance. This situation continues gender inequality in many parts of the world [59].

Presently, decision-makers are looking for ways and programs to involve men in reproductive health decisions, including family planning and support for safe motherhood. Previous programs have established that a supportive partner facilitates women's reproductive health and contraceptive usage. Women have been the main target of family planning campaigns at the expense of their male counterparts for a long time. Despite this, a greater percentage of women using contraception use a male contraceptive method or a contraceptive method that requires male cooperation [60].

The cause why men have a varied attitude than women and men exposed to family planning counseling at different levels and in the process of decision making, men have different experiences [61]. The authoritarian and patriarchal structure of family relationships also necessitates the approval of the man in using the family planning method. While most of the men in developing countries agree that responsibility is shared by couples, they believe that women should use family planning methods [62].

One of the biggest obstacles to men's participation in reproductive health is the inadequacy of information. Only male information about the contraception is not important, but also how it is used and its effectiveness is important. Various studies have examined how cultural and social organizations influence contraceptive patterns. Studies in Ghana and Nigeria show that women are at high level influence of male's population to contraceptive decisions; however the converse may not be true. In addition, men are effective at the first decade of reproductive marriage and up to the first four children. Males want more children in families with fewer members and it is seen how important the number of surviving children is for women [63, 64].

The importance of men's involvement in policy designs and research on reproductive health is also emphasized by other researchers. Bankole and Zulu claim that contraceptive unmet need data in Sub-Saharan Africa derives from data collected only for women [64, 65].

Men's positive approach makes it easier for women to access and use family planning services, and as a result, availability and continuity in services is ensured [66–68]. Participation of men in family planning involves using more male-oriented methods and supporting their partners in using the family planning method. It is very important for men to decide which method to use in family planning and to act together with women during the selection use and follow-up of methods [62].

Men should be able to lead and support his wife or use one of these methods himself. As a wife and a husband, they may be more aware of the needs of their spouse and family members and may make better plans for their children's future. Positive attitudes of men in family planning can enable their spouses to use their methods and go to the health institution regularly. They can also play an important role in the prevention of sexually transmitted diseases through the use of condoms regularly [62, 69].

Men's attitudes will be used in women's reproductive health decisions family planning methods. Many factors affect women's use of the family planning method, such as the educational status of women and their spouses, the number of children they have, the family structure, the point of view of men toward family planning and the disapproval of spouse or family elders [66, 68]. Dissatisfaction against existing methods in developed countries leads to new methods of searching for men [70].

In Zimbabwe, despite men report having "the final say" in contraceptive use, women are the ones responsible for obtaining contraceptives. These and other studies show that couples in contraceptive use are incompatible. The primary conclusion in past research is that men are on the contraception for the purpose of spacing for restricting family size. Men want more children, this suggests that reproductive health programs or policies in developing countries should occur in both genders. Note that most of the conclusions are derived from surveys where individuals prefer their own preferences and preferences. For this reason, it is necessary to work more accurately to measure the "unmet needs" of women, the difference between fertility preferences and the use of contraception [59].

One of the problems generated by unmet need for family planning is the occurrence of unwanted pregnancies that have impact on abortion. Given that one of the four pregnancies in the world is intentionally terminated, there is also evidence of male opinion about abortion, an important element in contraception. Abortion is perhaps the best example of a direct relationship between laws and policies and inadequate reproductive health outcomes, and in many countries it is men who write, confirm, and enforce abortion. For example, married women in Turkey need permission from their spouse to have an abortion. This situation is about Islamic law. In addition, men can directly influence women's decisions about abortion. For example, in an amniocentesis and abortion inquiry in New York, Rapp found that spouses' beliefs were largely influential on the rejection of prenatal tests such as contraceptive use or amniocentesis.

According to her results, women who felt that her partners would love and help increase a handicapped child were less likely to undergo such test, relying heavily on her partner's beliefs about the attraction of a handicapped child in their decisions about. The study by Browner for Colombia demonstrated the strong influence that spouse have on women's abortion decisions. When it is expressed directly or when it perceives that it will be abandoned,

the abortion rate increases [59]. Getting men involved in the family planning program will lead to increase the usage of contraceptives methods as a result will improve the continuous use of male method.

Identifying individuals' attitudes and behaviors toward the family planning, completing missing information and correcting false information are important to be able to provide an effective family planning service and for planning the training and consultancy services to be given to the women.

Health workers should be guided to choose the right method and use it correctly. This helps couples enhance the quality of their sexual lives. In order to potent scale up reproductive health service provision to meet the present-day and future needs, a sufficient number of educated health care professionals should be available. However, the inadequacy of health workers prevents the provision of family planning services, especially in rural areas. Experiences from some developing countries show that community-based family planning services have been used successfully to deliver family planning methods including distribution of pills as well as injectable contraceptives [71, 72].

Even though literature on uptake as well as methods used for family planning at community level in developing countries is available, literature on perceptions and attitudes of women toward the use of family planning services offered by community health workers is scarce [73].

Adults need more information about how family planning is useful in the severity and severity of known contraceptive side effects. A new literature survey of modern contraceptive use from qualitative research mentions about obstacles similar to contraceptive use for women, such as lack of knowledge, access and fear of side effects. In addition to school-based programs, media campaigns can help remove the myths surrounding the perceived health effects of contraceptive use.

In addition, more researches are needed among younger couples to develop communication and counseling about the family planning. This can be achieved by encouraging more male participation in contraceptive communication and decision-making processes, which may lead to increased use of family planning, better management of side effects and improved health relationships. As young women communicate with their peers and supportive family members, programs that encourage, build and support social networks will provide safe spaces for young adults to talk about the family planning and where they can access services [74].

As a result, more researches are needed in regards to knowledge and attitudes toward contraception use. The knowledge level in many countries of the world is high among both men and women, but the use of contraception is still low. In the future, qualitative research is needed for the reasons behind non-use contraception. Determination of attitudes and fears affecting contraception use could be a huge driver for increasing the prevalence.

Conflict of interest

There is no conflict of interest regarding the publication between authors.

Author details

Nazli Sensoy^{1*}, Yasemin Korkut², Selcuk Akturan³, Mehmet Yilmaz⁴, Canan Tuz³ and Bilge Tuncel⁵

*Address all correspondence to: nazsensoy@yahoo.com

1 Department of Family Medicine, Afyon Kocatepe University, Afyonkarahisar, Turkey

2 Department of Family Medicine, Dumlupinar University, Kutahya, Turkey

3 Department of Family Medicine, Erzincan University, Erzincan, Turkey

4 Family Health Center, Afyonkarahisar, Turkey

5 Ilic State Hospital, Erzincan, Turkey

References

- [1] Akgun S, Bakar C. Üreme sağlığı epidemiyolojisi: Türkiye’de doğurganlık ve aile planlaması. *Turkish Journal of Obstetrics and Gynecology*. 2006;**3**:9-18
- [2] Çayan A. 15-49 yaş evli kadınların aile planlaması yöntemlerine ilişkin tutumlarının kullandıkları kontraseptif yöntemler ile ilişkisi [thesis]. Aydın: Adnan Menderes University Health Sciences Institute; 2009
- [3] Ahman E, Shah IH. New estimates and trends regarding unsafe abortion mortality. *International Journal of Gynaecology and Obstetrics*. 2011;**115**:121-126. DOI: 10.1016/j.ijgo.2011.05.027. PMID: 21885049
- [4] Ahmed S, Li Q, Liu L, Tsui AO. Maternal deaths averted by contraceptive use: An analysis of 172 countries. *Lancet*. 2012;**380**:111-125. DOI: 10.1016/S0140-6736(12)60478-4. PMID: 22784531
- [5] Susheela S, Jacqueline D. Adding It Up: Costs and Benefits of Family Planning Services. Guttmacher Institute: New York; 2012
- [6] Moazzam A, Armando S, Asma R, Mario F, Marleen T. A global research agenda for family planning: Results of an exercise for the setting of research priorities. *Bulletin of the World Health Organization*. 2014;**92**:93-98. DOI: 10.2471/BLT.13.122242
- [7] Cleland J, Conde-Agudelo A, Peterson H, et al. Contraception and health. *Lancet*. 2012; **380**:149-156. DOI: 10.1016/S0140-6736(12)60609-6. PMID: 22784533
- [8] Family Planning 2020. Washington, DC: Family Planning 2020; 2012. Available from: <http://www.familyplanning2020.org> [Accessed: 2017-10-26]
- [9] Family Planning/Contraception. 2017. Available from: <http://www.who.int/mediacentre/factsheets/fs351/en/> [Accessed: 2017/10/20]

- [10] Canning D, Schultz TP. The economic consequences of reproductive health and family planning. *Lancet*. 2012;**380**:165-171. DOI: 10.1016/S0140-6736(12)60827-7. PMID: 22784535
- [11] Trends in maternal mortality: 1990 to 2010. Geneva: World Health Organization; 2012. Available from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf. [Accessed: 2017/10/26]
- [12] Arnold F, Zhaoxiang L. Sex preference, fertility, and family planning in China. *Population and Development Review*. 1986;**12**(2):221-246. DOI: 10.2307/1973109
- [13] Korra A. Attitudes toward Family Planning, and Reasons for Nonuse among Women with Unmet Need for Family Planning in Ethiopia. Calverton, Maryland USA: ORC Macro; 2002
- [14] Trends in Contraceptive Use Worldwide 2015. United Nations, Department of Economic and Social Affairs, Population Division. United Nations. New York, 2015. Available from: <http://www.un.org/en/development/desapopulation/publications/pdf/family/trendsContraceptiveUse2015Report.pdf>. [Accessed: 2017/10/11]
- [15] "2013 Turkey Population and Health Survey". Hacettepe University Institute of Population Studies, T.C. Ministry of Development and TUBITAK, Ankara, Turkey. 2014
- [16] Bishwajit G, Tang S, Yaya S, Fengcorresponding Z. Unmet need for contraception and its association with unintended pregnancy in Bangladesh. *BMC Pregnancy and Childbirth*. 2017;**17**:186. DOI: 10.1186/s12884-017-1379-4
- [17] Ali MM, Cleland JG, Shah IH. Causes and Consequences of Contraceptive Discontinuation: Evidence from 60 Demographic and Health Surveys. Geneva, Switzerland: WHO; 2012
- [18] Jain KA, Obare F, RamaRao S, Askew I. Reducing unmet need by supporting women with met need. *International Perspectives on Sexual and Reproductive Health*. 2013;**39**(3):133-141. DOI: 10.1363/3913313
- [19] Ross J, Stover J. Use of modern contraception increases when more methods become available: Analysis of evidence from 1982-2009. *Global Health Science and Practice*. 2013; **1**(2):203-212
- [20] Clark H, RamaRao S, Machiyama K, Thatte N. Expanding contraceptive choice. *Family Planning Evidence Brief*. 2017;WHO/RHR/17.14:1-4. Available from: <http://www.who.int/reproductivehealth/publications/familyplanning/expanding-contraceptive-choice/en/> [Accessed: 2017/10/15]
- [21] Ross JA, Heaton L. Intended contraceptive use among women without an unmet need. *International Family Planning Perspectives*. 1997;**23**(4):148-154
- [22] Ross JA, Winfrey WL. Contraceptive use, intention to use and unmet need during the extended postpartum period. *International Family Planning Perspectives*. 2001;**27**(1):20-27
- [23] Callahan R, Stan Becker S. Unmet need, intention to use contraceptives and unwanted pregnancy in rural Bangladesh. *International Perspectives on Sexual and Reproductive Health*. 2014;**40**(1):4-10. DOI: 10.1363/4000414

- [24] Bohner G, Wanke M. Attitudes and Attitude Change (Social Psychology: A Modular Course). 1st ed. NY: Psychology Press; 2002. 3-15 p. ISBN-13:978-0863777790
- [25] Arkonaç, SA. Social Psychology (Sosyal Psikoloji). 3rd ed. Istanbul: Alfa Press; 2005
- [26] Örsal Ö. Developing scale which is measurement attitude about family planning in Ankara Municipality Area [thesis]. Hacettepe University; 2005
- [27] Tanrıverdi G, Özkan A, Şenveli S. The choice reason of contraceptives methods on women in Canakkale. Fırat Medical Journal. 2008;**13**(4):251-254
- [28] Ayaz S, Efe ŞY. Family planning attitudes of women and affecting factors. Journal of the Turkish German Gynecological Association. 2009;**10**(3):137-141
- [29] Freedman JL, Sears DO, editors. Attitude and behavior. Trans. Dönmez A. Social Psychology 4nd ed. Ankara: İmge Bookstore; 2003. pp. 357-363
- [30] Örsal Ö, Kubilay G. Developing family planning attitude scale. İstanbul Üniversitesi Florence Nightingale Hemşirelik Dergisi. 2007;**15**(60):155-164
- [31] Kağıtçıbaşı Ç. Tutumlar. In: Kağıtçıbaşı Ç, editor. İnsan ve İnsanlar. İstanbul: Cem Ofset Matbaacılık; 1983. pp. 94-104
- [32] Yerli BE. The case of using family planning methods and influencing factors among the married woman aged between 15-49 in Erzurum city center [thesis]. Atatürk University, Erzurum; 2015
- [33] Price B, Hawkins K. Researching sexual and reproductive behaviour: A peer ethnographic approach. 2002;**55**(8):1325-1336. DOI: 10.1016/S0277-9536(01)00277-5
- [34] Freedman R, Coombs LC. Cross-Cultural Comparisons. Data on two factors in fertility behavior. New York: Population Council; 1974. 94 p. Available from: <https://www.popline.org/node/503493> [Accessed: 2017/10/9]
- [35] Lasee A, Becker S. Husband-wife communication about family planning and contraceptive use in Kenya. International Family Planning Perspectives. 1997;**23**(1):15-20 33
- [36] Greene ME. Changing women and avoiding men gender stereotypes and reproductive health programmes. IDS Bulletin. 2000;**31**(2):49-59. DOI: 10.1111/j.1759-5436.2000.mp31002007.x
- [37] Dudgeon MR, Inhorn MC. Men's influences on women's reproductive health: Medical anthropological perspectives. Social Science & Medicine. 2004;**59**(7):1379-1395. DOI: 10.1016/j.socscimed.2003.11.035
- [38] Sulthana B, Shewade HD, Sunderamurthy B, Manoharan K, Subramanian M. Unmet need for contraception among married women in an urban area of Puducherry, India. The Indian Journal of Medical Research. 2015;**141**(1):115-118
- [39] Ramaswamy SS, editor. Practical Contraception. Turnbridge Wells, England; 1976

- [40] Dude A, Neustadt A, Martins S, Gilliam M. Use of withdrawal and unintended pregnancy among females 15-24 years of age. *Obstetrics & Gynecology*. 2013;**122**(3):595-600. DOI: 10.1097/AOG.0b013e31829d8074
- [41] Helman CG, editor. *Culture, Health and Illness*. 4th ed. London: Wriqh; 2011. 369-370 p
- [42] Ahmed T. Pakistan Demographic and Health Survey 1990/91 and 2012-13, in Islamabad and Columbia. Vol. 1992. MD: Pakistan National Institute of Population Studies and Macro International; 2014
- [43] Shah NM, Shah MA, Radovanovic Z. Patterns of desired fertility and contraceptive use in Kuwait. *International Family Planning Perspectives*. 1998:133-138
- [44] Khalil B, Sarfraz M, Khan R. Socio-economic and demographic determinants of contraceptive uptake in Pakistan. *Pakistan Journal of Medical Research*. 2015;**54**(2):40-44
- [45] Vasundhara S, Uday M, Vinita D, Shally A. Socio demographic determinants and knowledge, attitude, practice: Survey of family planning. *Journal of Family Medicine and Primary Care*. 2012;**1**:43-47. DOI: 10.4103/2249-4863.94451
- [46] Murarkar SK, Soundale SG. Epidemiological correlates of contraceptive prevalence in married women of reproductive age group in rural area. *National Journal of Community Medicine*. 2011;**2**(1):78-81
- [47] Asimwe JB, Ndugga P, Mushomi J, Ntozi JPM. Factors associated with modern contraceptive use among young and older women in Uganda; a comparative analysis. *BMC Public Health*. 2014;**14**(1):926
- [48] Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü. "2013 Türkiye Nüfus ve Sağlık Araştırması". Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü. Ankara, Türkiye. Available from: http://www.hips.hacettepe.edu.tr/tnsa2013/rapor/TNSA_2013_ana_rapor.pdf; T.C. Kalkınma Bakanlığı ve TÜBİTAK; 2014 Accessed: 2017/10/15
- [49] National Family Health Survey (NFHS-III), India. International Institute for Population Sciences (IIPS) and Macro International. [Online] 2007;**1**:192-222. Available from: <http://www.nfhsindia.org> [Last cited on 2007]
- [50] Mosher WD, Martinez GM, Chandra A, Abma JC, Willson SJ. Use of contraception and use of family planning services in the United States: 1982-2002. *Advance Data*. 2004;**10**:1-36
- [51] Tuladhar H, Marahatta R. Awareness and practice of family planning methods in women attending gyne OPD at Nepal Medical College Teaching Hospital. *Nepal Medical College Journal*. 2008;**10**(3):184-191
- [52] Çuhadaroğlu A. The effects of sex education on psychological counselling students in Turkey. *Sex Education*. 2017;**17**(2):209-219. DOI: 10.1080/14681811.2016.1164132
- [53] Esselman J: Male Involvement in family planning: A Review of Experience. January 1996 Document Number: (PN-ABZ-226). Research and Reference Services United States Agency for International Development Center for Development Information and Evaluation Room 203, SA-Washington, D.C. 2010;**4**(1):53-8

- [54] Wahid I, Khan AD, Ata AM. Assessment of knowledge, attitudes and practices of married men towards family planning services in Peshawar, Khyber Pakhtunkhwa, Pakistan. *NJMS*. 2016;**1**(3):96-102
- [55] Hardee K, Croce-Galis M, Gay J. Are men well served by family planning programs? *Reproductive Health*. 2017;**14**:14. DOI: 10.1186/s12978-017-0278-5
- [56] Martin TC. Women's education and fertility: Results from 26 demographic and health surveys. *Studies in Family Planning*. 1995;**26**(4):187-202. DOI: 10.2307/2137845
- [57] Central Statistics Authority [Ethiopia] and ORC Macro. Ethiopia Demographic and Health Survey. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro [Internet]; 2005. Available from: <https://dhsprogram.com/pubs/pdf/FR118/FR118.pdf> [Accessed: 2017/11/01]
- [58] Berhane Y. Male involvement in reproductive health. *Ethiopian Journal of Health Development*. 2006;**20**(3):1-2
- [59] Farré L. The Role of Men in the Economic and Social Development of Women: Implications for Gender Equality. Policy Research Working Paper. 2013; No. 6323. World Bank, Washington, 1-37. Available from: <https://openknowledge.worldbank.org/handle/10986/12171> License: CC BY 3.0 IGO." [Accessed: 2017/11/01]
- [60] Oyieke JO, Galang DD. Knowledge, attitudes and cultural practices: Their influence on male involvement in reproductive health. *Baraton Interdisciplinary Research Journal*. 2016;**6**:139-149
- [61] Thorburn S. Attitudes toward contraceptive methods among African-American men and women: Similarities. *Women's Health Issues*. 2007;**17**:29-36
- [62] Altay B, Gönener D. Recognize and utilization of the family planning method among married males and the factors that affect the utilization of these services. *Firat Medical Journal*. 2009;**14**(1):56-64
- [63] Ezeh AC. The influence of spouses over each other's contraceptive attitudes in Ghana. *Studies in Family Planning*. 1993;**24**(3):163-174
- [64] Bankole A, Westoff CF. The consistency and validity of reproductive attitudes: Evidence from Morocco. *Journal of Biosocial Science*. 1998;**30**:439-455
- [65] Zulu EM, Dodoo FN, Chika-Ezee A. Sexual risk-taking in the slums of Nairobi, Kenya. *Population Studies (Camb)*. 2002;**56**(3):311-323
- [66] Göçgeldi E. editors. 6. National Reproductive Health and Family planning Congress Book. Üreme sağlığına erkeklerin katılımının artırılması: Türk Silahlı Kuvvetleri Üreme Sağlığı Programı. Ankara: Turkey; 2009. 56-59 p
- [67] Gunay T, Kılıç B, Kartal M, Sahin A. A step towards increasing man involvement in family planning: Family planning education for conscripts. *Turkey Clinics J Gynecol Obst*. 2007;**17**:283-291

- [68] Depe Y, Ayten Ş. Views and behaviors of men about family planning. Republican University Nursing High School Journal. 2006;**10**:29-36
- [69] Şankazan S, Yıldız A. Ankara ili Deliler Köyü'ndeki evli erkeklerin aile planlaması ile ilgili bilgi tutum ve davranışları. Ankara University Medical Faculty Journal. 2002;**55**(1):41-50
- [70] Westhoff C. Emergency contraception. The New England Journal of Medicine. 2003;**349**:1830-1835. DOI: 10.1056/NEJMcp031990
- [71] Hoke TH, Wheeler SB, Lynd K, Green MS, Razafindravony BH, Rasamihajamanana E, Blumenthal PD. Community-based provision of injectable contraceptives in Madagascar: 'task shifting' to expand access to injectable contraceptives. Health Policy and Planning. 2012;**27**(1):52-59. DOI: 10.1093/heapol/czr003
- [72] White JS, Speizer IS. Can family planning outreach bridge the urban-rural divide in Zambia? BMC Health Services Research. 2007;**7**:143. DOI: 10.1186/1472-6963-7-143
- [73] Juma PA, Mutombo N, Mukiira C. Women's attitudes towards receiving family planning services from community health workers in rural Western Kenya. African Health Sciences. 2015;**15**(1):161-170. DOI: 10.4314/ahs.v15i1.22
- [74] Irani L, Speizer I, Barrington C. Attitudes, beliefs and norms relating to contraceptive use among young migrant and non-migrant adults in urban Dar es Salaam, Tanzania. Global Public Health. 2013;**8**(9):1048-1062. DOI: 10.1080/17441692.2013.838598