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Research Article

Study of knowledge and contraception practices in low socio-economic women of Delhi

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ABSTRACT

Background: Objective of current study was to assess the knowledge and practice of contraception among the low socio-economic women of reproductive age group in Delhi.
Methods: A cross-sectional study was done on 272 low socio-economic women attending a family planning clinic at a Delhi municipal corporation hospital, of which 106 came for Medical Termination of Pregnancy (MTP) and 166 came for family planning advice. They were interrogated through a pre-designed structured questionnaire, to evaluate their knowledge and practices towards regular contraceptive methods, Emergency Contraception (EC) and medical abortion. They were counselled about the available contraceptive methods and allowed to make choices according to their suitability.
Results: All women belonged to low socio-economic group according to the modified Kuppuswamy scale. 22.1% were illiterate. 47.8% were ignorant of contraception. 38.3% women were aware of EC. Only 24.2% knew about medical abortion. The main reasons cited for not using contraception was desire for male child (24.6%), fear of side effects (20%), desire for another child (20%), opposition from family members (15.4%), inaccessibility (4.6%) and inconvenience and lack of privacy (5.4%).
Conclusions: This study highlights that lack of education, knowledge and awareness led to inadequate usage of regular methods of contraception in reproductive age group women belonging to low socio-economic status. Thus only availability is not sufficient to reach optimum female health. Accessibility need to be increased by educating females and motivating couples to make adequate use of existing family planning methods and resources. In contrast the awareness for emergency contraception is more than regular methods. It mandates need to educate women that emergency contraception should not replace regular methods.

Keywords: Knowledge, Practice, Medical abortion, Emergency contraception, Contraception, Low socio-economic, Delhi.

INTRODUCTION

India, being the second most populous country in the world, with population reaching 1.21 billion and decadal growth rate of 17.64% as per the 2011 census, population control is one of the major issues to be addressed by the Indian government. The efforts on the part of the government are to control the situation by making availability and accessibility of the family planning methods. After implementing National Family Planning Program in 1951, due emphasis and importance has been laid on it in almost all successive five year plans. But despite farsightedness of Indian government, the goal has not yet been achieved. There are still miles to go to reach the total fertility rate of 2.1 as set by National Population Policy 2000.[1] Contraception methods decrease the total fertility and provide proper spacing of pregnancies to reduce the maternal morbidity and mortality.[2] Despite

constant government efforts, the 'unmet need of contraception' which refers to a disparity between woman's fertility preferences and her family planning practices, still persists.[3]

The present study aimed to assess the knowledge and practice of contraception methods among reproductive age, low socio-economic status women of Delhi.

METHODS

272 women of reproductive age group, belonging to lower and lower upper socio-economic class according to the Modified Kuppuswamy scale, attending the family planning clinic of a municipal corporation hospital, who came to seek family planning advice (after being referred from general gynaecology OPD for contraception counseling) and for Medical Termination of Pregnancy, over a period of two months were evaluated for their knowledge and practices towards regular contraceptive methods, emergency contraception and medical abortion with the help of a structured questionnaire. Women were then given the cafeteria choice of different contraception methods available and contraceptive method accepted by them was recorded and analysed statistically.

RESULTS

Table 1 shows the socio-demographic characteristics of the studied sample.

Table 1: Demographic characteristics of the studied sample of women.

Characteristics	No. of women (n=272)	Percentage (%)
Medical termination of pregnancy cases	106	39
Family planning advice seekers	166	61
Age		
Range	20-40 year	
Mean Age	26.4 years	
Parity		
0	2	0.7
1	20	7.4
2	56	20.6
3	75	27.6
4	113	41.5
>4	6	2.2
Education		
Illiterate	60	22.1
Primary	186	68.4
Secondary and above	26	9.5
Socio-economic status		
Lower	177	65
Lower upper	95	35

Of 272 women, 39% (106) came for Medical Termination of Pregnancy (MTP) while 61% (166) came to seek family planning advice. Mean age of the studied women was 26.4 years, 43.7% being of parity four or above. 22.1% were illiterate while 68.4% had only primary education.65% belonged to lower while 35% belonged to upper lower socio-economic class as per the modified Kuppuswamy scale (Table 1).

From Table 2, it is seen that, while 47.8% had no knowledge of any contraceptive methods, 21.7% were using Intrauterine Contraceptive Device (IUCD) followed by Barrier contraceptive usage by 18.8%. Oral contraceptive pills were used only by 4.4%. 24.2% were aware of Medical Abortion (MA) while only 17% had actually used it. Similarly 38.3% were aware of Emergency Contraception (EC) while 24.6% had actually used it. Of 106 women who came for MTP, 62.3% had unplanned pregnancy, while 35.8% had failed contraception. 65% of females were unaware of non-contraceptive benefits of the various methods.

Table 2: Knowledge and practice of contraception, medical abortion and indication for medical termination of pregnancy (n=272).

Characteristics	No. of women (n=272)	Percentage (%)
Use of contraception (n=272)		
No contraception	130	47.8
Barrier method	51	18.8
Intra uterine contraceptive device	59	21.7
Oral contraceptive pills	12	4.4
Others	20	7.3
Knowledge of medical abortion (n=272)		
Heard about medical abortion	66	24.2
Used medical abortion	46	17
Unaware	160	58.8
Knowledge of emergency contraception (n=272)		
Heard of EC	104	38.3
Used EC	67	24.6
Unaware	101	37.1
Indications of medical termination of pregnancy (n=106)		
Unplanned pregnancy	66	62.3
Failed contraception	38	35.8
Poor maternal health	2	1.9
Knowledge of non-contraceptive benefits		
No knowledge	177	65
Knowledge present	95	35

Table 3 shows, while desire for male child was most common (24.6%) reason for not using contraception, fear of side-effects and desire for further conception was seen in 20% each.15.4% cited family/spouse opposition as a cause. 4.6% accounted for inaccessibility to family planning services while 5.4% said inconvenience was the main reason.

Table 3: Reasons for not using contraception.

Reason	No. of women (n=130)	Percentage (%)
Worried of side effects	26	20
Opposition from family members/spouse	20	15.4
Wanted male child	32	24.6
Wanted conception	26	20
Inconvenience/lack of privacy	7	5.4
No access to family planning services	6	4.6

Post counselling, (Table 4) most common form of contraceptive adopted by group 1 was IUCD (56.7%) followed by permanent method of sterilization (40.6%). While those who came for family planning advice, maximum (41.6%) inclined for barrier contraceptive followed by IUCD (31.2%). Oral Contraceptive Pills (OCPs) and permanent method of sterilization were adopted by 10.2% and 9.6% respectively.

Table 3: Contraception form accepted after counseling.

Characteristics	No. of women (n=272)	Percentage %
Group 1 [Medical termination of pregnancy group (n=106)]		
Oral contraceptive pills	2	1.9
Intra uterine contraceptive devices	59	56.7
Bilateral tubal ligation	43	40.6
Barrier method	2	1.9
Others		
Group 2 [Family planning group (n=166)]		
Oral contraceptive pills	17	10.2
Intra-uterine contraceptive devices	53	31.2
Bilateral tubal ligation	16	9.6
Barrier method	69	41.6
Change of IUCD	11	6.6

DISCUSSION

The mean age of patient in our sample was 26.4 years. Most of them were of high parity, probably because more the number of children, more was the likelihood of her wanting contraception. Similar result was also reflected by Imasiku et al. where the average parity of women seeking contraception was 6.7.[4] All patients in our study belonged to low socio-economic status, 22.1% being illiterate and 68.4% with only primary education. This was similar to the study sample of Tuladhar et al.[5]

Inspite of availability of safe and effective contraception methods only half (52.2%) females were aware of the available contraceptive methods. This lack of awareness was probably due to low literacy status and low socio-economic status. This was in contrast to 94.2% awareness according to Renjhen P et al., 94% according to Zafar et al., 95.8% as per a Korean study and even upto 100% according to Srivastava et al.[6-9] This difference was due to higher socio-economic and literacy status of these populations.

However our result was similar to the study in Nigeria which also showed low awareness of 54.3% and that by Srivastava et al., where it was only 17%.[10,11]

Women's low literacy status is one of the factors affecting the knowledge regarding contraception. This was also reflected in the study by Srivastava et al and Ali et al.[11,12] Another study conducted in Bombay also concluded that education was the main variable and main influencing factor in the decisions regarding family size and contraceptive awareness.[13] Similarly Gautam et al. in their study concluded that raising education level will help in improving acceptance of contraceptive devices.[14] Thus low literacy level among the women stresses the need for stressing upon female education as a key factor to combat over-population and to encourage the contraceptive use.

Educating girls and young women is particularly important for their empowerment, health and the well-being of their families and communities in turn. It helps women to become critical consumers of information, enabling them of distinguishing between correct and incorrect facts.

In 1975, Tietze and Bongaarts observed that "levels of fertility required for population stabilization cannot be easily obtained without induced abortion".[15] When safe abortion is accessible in a country, the Total Fertility Rate (TFR) is likely to be one child lower than if abortion is not accessible.[16] Similarly emergency contraception provides a safe and effective means of post coital contraception and has been estimated to prevent atleast 75% of pregnancies expected from unprotected sexual intercourse.[17] In contrast to low awareness of regular contraception in the females belonging to the low socio-economic status and low literacy level, awareness rates for MA and EC in this class, were 24.2% and 38.3% respectively. This was due to availability of these drugs as 'over the counter drugs' and role of mass media in promoting them. The potential benefits of EC are most evident in Sub Saharan Africa like Nigeria, where regular contraceptive prevalence is low and unwanted pregnancies with unsafe abortions are rampant.[18] Very few family planning programs have incorporated EC as part of their routine services.[19] To avoid misuse, medically unsupervised usage and wrong dosing (as these are available as "over the counter drug") and hence increased failure rates, the women should be familiarized about the proper usage regime and failure rate of EC and MA pills, when they come for routine contraceptive advice. This knowledge will enhance the proper usage and thus help in more participation with increase in the success rates. The population of women seeking

emergency contraception or medical abortion is most receptive for further contraceptive use and should be another 'target group' for family planning counselling.

One fourth (24.6%) of studied population did not use contraception in the desire of male child. This shows male child preference still prevailing the Indian society especially in low socio-economic class. 20% of women in our study refrained from using contraception due to fear of side effects. Fear of side effects and misconceptions is wide spread and has been the most important explanation for non-use of contraception.[20-24] In many cultures and contraceptives are perceived as more dangerous than childbirth.[24] Many Africans believe that pills and injectables lead to infertility. Even the religious rules and value systems often limit the mobility and decision making capacities of women.[25] Opposition from the family members/spouse was seen in 15.4%. This is really sad for country like India where the male dominance still prevails which forbids the women from her independent decision making. Considering this, husband and mother in law should be aimed as 'target groups' for contraception counselling for better adoptability of a method. Low income women have fewer opportunities for getting necessary information, so easier access to reproductive health education should be priority. Similarly low income females also don't seek medical care owing to their limited income. So government should make strategies of making family planning services more accessible and affordable.

Thus many of the barriers to family planning are there which remain ignored by government as well as private organizations, viz. shortfalls and breaks in commodity supplies, arbitrary medical rules and restrictions before contraception can be used, unaffordable prices, laws restricting the provision of safe abortion as well as widespread misinformation about contraception.[25] The knowledge of non-contraceptive knowledge of non-contraceptive benefits was present in one-third of the studied sample. Making them aware of these potential benefits probably will make them more acceptable.

62.3% went for MTP for unplanned pregnancy which was due to lack of use of regular contraceptive methods. This reflects the impulsive nature of human sexual behavior. Although government of India is trying to meet the unmet needs of contraception, but many women still end up in unwanted pregnancy and request for MTP. Despite availability of government/government approved MTP centers, owing to their low literacy status reach unqualified practitioners for unsafe abortion and land up in septic abortion which is still a major cause of maternal mortality and morbidity in India.

In our study most of the MTP seeking women went for IUCD (56.7%) followed closely by sterilization (40.6%). This behavior was probably as a result of the discomfort of surgery, which made them to go for permanent or at least a long lasting method. After completing family, females tend to choose a more permanent form of contraception. Younger women with incomplete females tend to choose temporary methods. However in family planning seeking group, use of barrier methods (male condom) was maximum (41.6%) signifies the influence of male dominance in decision making of females. But high failure rate associated with barrier usage should be emphasized and use of other methods with low failure rates should be stressed on the women. The responsibility on the part of government and private medical organisations is to make availability and accessibility to the regular contraception methods by clearing all doubts regarding side effects, allaying anxiety and misconceptions, empowering women by increasing the education level, highlight the contraceptive and non-contraceptive benefits. All post-partum women must receive adequate family planning advices during their postnatal follow-up visits.

However this study had several limitations. The sample size was small, moreover since most of the women came alone, so male partners and family members influencing the decision making of females especially mother-in-laws were not directly involved in the study. As they have major influence on adoption of a particular contraception, in country like India, are the major target groups who need to be focused on and involved in the study. Inspite of every possible effort to obtain the correct information, possibility of misreporting cannot be ruled out keeping in view the low literacy level of the females in study. Further research is needed on reasons of premature discontinuation of a specific method. In order to bridge the gap between knowledge and practice of contraception, there must be regular uninterrupted availability and supply of contraceptive methods and good quality of family planning services both at government and private sectors. Alternative methods of contraception must be informed and offered so as to improve the rate of contraception utilization

Its high time for our policy makers to adopt the "opportunity model" given by Campbell MM et al. which says 'whenever women have access to a range of contraceptive methods with correct information backed up by safe abortion, fertility will fall'.[25]

CONCLUSIONS

There still remains a gap between knowledge and practice of contraception especially in low socio-economic class which needs to be bridged. Family planning counseling needs to be universally included into routine antenatal and postnatal clinics. It should include non-contraceptive health benefits messages too. Moreover emphasis should be laid on promoting female education and thus women empowerment to enable them of independent decision-making especially in issues pertaining to their health. Role of mass media like T.V. should be utilized efficiently in spreading awareness among the lower socio-economic and lower literate strata of society. Besides, the government and private medical sectors

should play important role in allaying and dispelling the prevailing misinformation and misconception, making methods available, accessible and affordable. Emergency contraception and medical abortion should be made part of family planning programs and should be administered under medical supervision to enhance their success rates.

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