"Preferred Choices And The Problems Related With The Methods Of Contraception Adopted By Married Women Attending Selected Family Welfare Clinics Of Kashmir"

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Abstract: The best decisions about family planning are those that people make for themselves, on accurate information and from a range of contraceptive options. People who make informed choices are better able to use family planning safely and effectively. Providers of family planning programs have a responsibility to help people make informed family planning choices. One of the main reasons for lower adoption of contraceptives in India is the myths that have been built around them. This is primarily due to the lack of correct information on contraceptive methods. Contraceptive behavior is characterized by four parameters namely, knowledge of contraception, current contraceptive use, future intention to use contraception and desire for additional children. A study to identify the knowledge, preferred choices and the problems related with the methods of contraception adopted by married women attending selected family welfare clinics of Kashmir and seek relationship with selected factors Age, education, occupation, religion, type of family, income and no. of children, objection on contraception use. The sample size consisted of 100 married women attending family welfare clinics of Kashmir. Half of the women using contraceptive devices, (50%) were in the age group of 21-30year. (40%) were illiterate. More than half of the subjects (52%) were house wives/ domestic helpers. Majority of the women 98 (98%) were Muslims. (42%) belongs to nuclear family. (45%) were in the monthly income group between Rs 1001- Rs 15,000 income group. More than half of the married women (54%) were having three or more children. (100%) subjects respond that they don't have any objections from any family members. Condoms (36%) and Multiload (25%) are the most popular methods used, whereas Norplant, RISUG, female condoms and vasectomy are not used at all.But among the married women, who have not used but have preferences, Tubectomy (30%) is most preferred method and Norplant, RISUG and Vasectomy are not preferred at all. Majority 14 (87.5%) of married women reported that they face difficulty in recording the body changes carefully, Majority of the subjects 28 (77.7%) reported that they fell Embracement while buying condoms, Majority 14 (70%) of the subjects reported

Unexplained vaginal bleeding and breast tenderness after taking oral pills, Majority 19 (95%) reported white discharges while using copper-T, Majority 19 (95%) reported white discharges while using Multiload, Majority 6 (60%) of married women faced general weakness after tubectomy. The education, occupation, have significant relationship with knowledge score but there is no significant relationship between age, income and no. of living children, type of family and knowledge score of married women using various contraception methods at 0.05 level. The mean of knowledge score was 24.69, the median was 24, and the mode was 21. The mean score was 24.69 and mostly the subject's fall below mean knowledge score, it is significant that the subjects are having less knowledge regarding various contraceptive devices. The standard deviation was 5.42, depicting that there was not much of variation of knowledge scores among married women for various contraceptive methods. Maximum problems were reported by the married women after using copper-T and minimum problems with Tubectomy.

Index terms: Preferred Choices, methods of contraception.

1.1 Introduction:

The bond that links your true family is not only of blood, but of respect and joy in each others life.

(Richard Bach)

The best decisions about family planning are those that people make for themselves, on accurate information and from a range of contraceptive options. People who make informed choices are better able to use family planning safely and effectively. Providers of family planning programs have a responsibility to help people make informed family planning choices. One of the main reasons for lower adoption of contraceptives in India is the myths that have been built around them. This is primarily due to the lack of correct information on contraceptive methods. Contraceptive behavior is characterized by four parameters namely, knowledge of contraception, current contraceptive use, future intention to use contraception and desire for additional children. Knowledge of contraception is defined as complete knowledge (awareness) of all the major methods of population stabilization - sterilization, the IUD, oral pill and condom and the decision on the contraceptive of choice should be based on the right information, and not myths.

Studies have found that most couples in fact regard family planning positively. However, the common fertility pattern in India diverges from the two-child family that policy makers hold as ideal. Women continue to marry young; in the mid-1990s, they average just over eighteen years of age at marriage. When women choose to be sterilized, financial inducements, although helpful, are not the principal incentives. On average, those accepting sterilization already have four living children, of whom two are sons. Family planning means having only the number of children you want and only when you want to have them. There are a number of birth control methods available to protect unwanted pregnancies. The risk of serious illness or death resulting from pregnancy is far greater than the risk involved in using any birth control method. Birth control also eliminates the unnecessary need for abortions. Abortions after three months risk the mother's life and impair her chances of a healthy pregnancy later. This risk is compounded because many abortions are done in secret by unskilled persons in unclean surroundings causing infections and death. Sensible birth control prevents this needless suffering and death. More over the people of Kashmir do not accept various contraceptive methods. The **National Population policy 2000,** adopted by the Government of India has set as its immediate objective the task of addressing unmet need of contraception in order to achieve the medium-term objective of bringing the total fertility rate down to replacement level by the year 2010. One of the 14 national socio-demographic goals identified for this purpose is to achieve universal access to information/ counselling and services for fertility regulation and contraception with a wide range of choices**. (Ministry of health and family welfare, 2000).** On 11 May, 2000 India is having 1 billion[3] (100 crore) people, i.e. 16 percent of the world's population on 2.4 percent of the globe's land area. If current trends continue, **India may overtake China in 2045**, to become the most populous country in the world.

While global population has increased threefold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million (23 crores) to 1 billion in the same period. India's current annual increase in population of 15.5 million is large enough to neutralize efforts to conserve the resource endowment and environment. Stabilising population is an essential requirement for promoting sustainable development with more equitable distribution. However, it is as much a function of making reproductive health care accessible and affordable for all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communications.

Lack of knowledge about the contraceptive method can be a major obstacle to their use. There are many like religion, type of family, house hold, income, and number of living children and mother's level of education which affects the pattern of contraceptive use. Another important factor that restricts the use of contraceptives is the fear of side effects. In many countries such effects. In many countries such concerns about the side effects of contraceptives originating from experience from family, friends and rumors which are told and retold through the communities have contributed to low contraceptives acceptance. In a study conducted by ***Kathmandu university Researchers, 2006, stated*** that three-fourth women mentioned weakness as a side effect after tubectomy and OCP use . This misconception of weakness after sterilization was also observed by other researchers **(Priyadarshani.A. 2005).** The need of the study was felt by the investigator after realizing the current population expansions of the country, current maternal mortality rate due to unsafe abortion, unintended pregnancies, and a huge unmet need of family planning services inspite of the nation's efforts through various national family planning programmes to improve the utilization of family planning services still. So, the investigator felt the need to conduct the study to assess the knowledge, preferred choices, and the problems faced regarding methods of contraception adapted by married women. this study helped to identify the knowledge of married women for various methods of contraception, their preferences for various methods and what problems they had faced or facing after using various contraceptive methods, which helped us to know why women are discontinuing contraceptive devices and what are the factors that influence their decision for choosing various family planning methods.The conceptual framework of the study was based on the "Health Belief Model".

SR Patrikar, Col R Bhalwar, et al 2008 conducted a study to assess the attitude of women towards birth of son, use of contraception methods and sex determination methods in rural village Kasurdi in Pune district. Univariate analysis was carried out by considering each factor determining sex preference separately as well as using a Logistic Regression Model. Result and Conclusion was that Out of 110 respondents interviewed, 62.7% felt that male child is necessary in the family. Univariate analysis revealed that sex of first child, concern undergone for second pregnancy with regards to sex of the child, number of children in family and type of family were significant factors contributing to the son preference.

Juell B. Homco, Jeffrey F. Peipert, et al (2008) conducted a survey on Reasons for ineffective pre-pregnancy contraception use in patients seeking abortion services. Participants (*n*=298) ranged in age from 18 to 48 years were taken. One third reported contraceptive use prior to pregnancy (37%). Approximately 72% of women reported some reason for not obtaining desired contraception, while 34% reported two or more. The distribution of reported individual, institutional, and compliance reasons were 44%, 28%, and 24%, respectively. Report of at least one reason was associated with a 35% increase in non-use after adjusting for age, race, education, parity, and prior abortion. Many reasons for not obtaining desired contraception exist and are associated with non-use of contraception. Removing these reasons may help reduce unintended pregnancies and rates of pregnancy termination

Ruth Schule and Syed M. Hashmi, 2007 conducted a research on Women's Empowerment, and Contraceptive Use in Rural Bangladesh The findings of research addressing the question of how women's status affects fertility. The effects on contraceptive use of women's participation in rural credit programs and on their status or level of empowerment were examined. A woman's level of empowerment is defined here as a function of her relative physical mobility, economic security, ability to make various purchases on her own, freedom from domination and violence within her family, political and legal awareness, and participation in public protests and political campaigning. The main finding is that participation in both of the credit programs studied, those of

Grameen Bank and Bangladesh Rural Advancement Committee (BRAC), is positively associated with women's level of empowerment. A positive effect on contraceptive use is discernible among both participants and nonparticipants in Grameen Bank villages. Participation in BRAC does not appear to affect contraceptive use.

1.2 Problem Statement: A study to identify the knowledge, preferred choices and the problems related with the methods of contraception adopted by married women attending selected family welfare clinics of Kashmir.

1.3 Objectives:

1. The main objectives of the study were to assess the knowledge of married women regarding various methods of contraception.

2. To identify the preferred methods of contraception (temporary or permanent) among married women.

3. To determine the knowledge of married women regarding problems related with the use of various temporary and permanent methods of contraception. To find out the association of knowledge of married women regarding family planning methods with selected factors i.e. Age, Education, Occupation, Income, Type of family, Number of living children, Type of contraceptive used/using. To find out the most occurring and least occurring problems due to a contraceptive method in use.

2. Research Methodology:

2.1 Research Approach and Design: The research approach adopted for the study was the Descriptive Survey approach.

2.2 Population and Sample: The population consisted of 100 married women attending family welfare clinics of Kashmir. The Purposive sampling technique was used to obtain an adequate size of sample.

2.3 Research Tools: The tool developed and used for data collection was structured interview schedule to obtain data regarding the knowledge, preferences and problems faced by married women regarding various contraceptive devices.

2.4 Data Collection Method: The structured interview schedule was administered to 100 married women after taking the formal permission from the Medical superintendent of selected hospitals.Women were explained the nature of the study and their expected participation in the study. Then individual women were interviewed with structure interview schedule to assess the knowledge, preferences and the problems faced related to various methods of contraception. No problems were faced during the study.

2.5 Data Analysis: Results were analyzed through descriptive and inferential statistics.

III.RESULTS AND DISCUSSION: The analyzed data was organized and presented in the form of tables which was organized under the following sections:

SECTION-I

TABLE –1
Frequency and percentage distribution of married women by demographic data.
n=100

Sample characteristics	Frequency	Percentage
AGE		
Below 20 years	0	0%
21- 30 years	50	50%
31- 40 years	35	35%
40years and above	15	15%
Education		
No basic education	40	40%
Primary		
Secondary	30	30%
Graduate	12	12%
Post graduate	10	10%
	8	8%
Occupation		
		52%
House wife/ Domestic help	52	
Professionals	20	20%
Skilled worker	25	25%
Unskilled worker	3	3%
RELIGION		
Islam	98	98%
Hindu	0	0%
Sikh	2	2%
Christianity	0	0%
Others	0	0%
TYPE OF FAMILY		
Nuclear	42	42%
Joint	30	30%
Extended	28	28%

MONTHLY INCOME		
Below 5000	25	25%
Rs 5001- Rs 10,000	20	20%
Rs 1001- Rs 15,000	45	45%
Rs 15001 and above	10	10%
NUMBER OF LIVING CHILDREN		
One	4	4%
Two	22	22%
Three or More	54	54%
No children	20	20%
OPPOSITION FROM FAMILY MEMBERS		
Yes	0	0%
No	100	100%

TABLE – 2

Frequency and percentage distribution of married women using various contraceptive devices by the types of contraception used / using.

N=100

Sample characteristics	Frequency	Percentage
TYPES OF CONTRACEPTION		
Rhythm method	16	16%
Male condom	36	36%
Female condom	0	0%
Copper-T	20	20%
Multiload	25	25%
Oral pills	20	20%
Norplant	0	0%
Injections	25	25%
RISUG	0	0%
Traditional method	5	5%
Tubectomy	10	10%
Vasectomy	0	0%
No methods	20	20%

Subjects were free to give more than one response.

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TABLE - 3

Frequency distribution of sample subjects by preferences for various contraceptive devices
n=100

Methods of contraception	Number of subjects who have used and have preference		Number of subjects who had not used but have preference for the given method		Total*
	Frequency	Percentage	Frequency	percentage	
Rhythm method	23	23%	8	8%	31
Male condom	36	36%	25	25%	61
Female condom	0	0%	2	2%	2
Copper-T	20	20%	5	5%	25
Multiload	25	25%	15	15%	40
Oral Pills	20	20%	4	4%	24
RISUG	0	0%	0	0%	0
Injections	25	25%	5	5%	25
Traditional method	5	5%	0	0%	5
Tubectomy	10	10%	30	30%	40
Vasectomy	0	0%	0	0%	0

Subjects were free to give more than one response.

TABLE- 4

Frequency and percentage distribution of sample subjects by problems faced in using rhythm method

n=23

S. NO	PROBLEMS FACED	FREQUENCY	PERCENTAGE
1.	**<u>Rhythm methods</u>**		
	Husband's non-cooperation.	4	17.3%
	Difficulty in calculating date and time. .	10	43.4%
	Difficult to identify safe period. .	12	52.1%
	Difficulty to record carefully the body changes.	22	95.6%

Subjects were free to give more than one response

TABLE -5

Frequency and percentage distribution showing problems faced in using male condoms

n=36

S. NO	PROBLEMS FACED	FREQUENCY	PERCENTAGE
2.	**Male condoms**		
	Itching	12	33.3
	Decreased sensation	26	72.2
	Time consuming.	12	33.3
	Pain	2	5.5
	Expensive.	0	0
	Slipping	14	38.8
	Rupture during sex.	23	63.8
	Difficulty in storage.	26	72.2
	Lack of husband's cooperation	6	16.6
	Embracement while buying.	28	77.7

Subjects were free to give more than one response.

TABLE -6

Frequency and percentage distribution showing problems faced after using oral pills

n=20

S. NO	PROBLEMS FACED	FREQUENCY	PERCENTAGE
3.	**Oral pills**		
	Amenorrhea	8	40
	Minor headache	12	60
	Sporting or bleeding	12	60
	Unexplained vaginal bleeding	14	70
	Stomach upset	6	30
	Breast tenderness	14	70
	Painful menstruation	8	40
	Flushing lights/hot flushes	6	30
	Weakness	5	25

Subjects were free to give more than one response.

TABLE -7

Frequency and percentage distribution showing problems faced   after using injectables

n= 25

S.NO	Problems Faced	Frequency	Percentage
4	Bleeding or spotting.	15	60%
	Heavy menstrual periods	10	40%
	Dysmenorrhea	5	20%
	Abdominal pain	2	8%
	Fever	0	0%
	Headache	0	0%
	White discharges	14	56%
	Backache	8	32%
	• Irregular menstrual bleeding	16	64%

Subjects were free to give more than one response

TABLE -8

Frequency and percentage distribution showing problems faced after using copper-t

n=20

S. NO	PROBLEMS FACED	FREQUENCY	PERCENTAGE
4.	**Copper- T**		
	• Irregular menstrual bleeding	18	90%
		18	90%
	Bleeding or spotting.	16	80%
	Heavy menstrual periods	14	70%
	Dysmenorrhea	15	75%
	Abdominal pain	0	0%
	Fever	0	0%
	Headache	19	95%
	White discharges	6	30%
	Dissatisfaction	0	0%
	Expulsion of the device.	18	90%
	Backache	8	40%
	Needs regular checkups		

Subjects were free to give more than one response.

TABLE -9

Frequency and percentage distribution showing problems faced after using multiload

n=25

S. NO	PROBLEMS FACED	FREQUENCY	PERCENTAGE
5.	**Multiload**		
	Irregular menstrual bleeding	10	40%
	Bleeding or spotting.	8	32%
	Heavy menstrual periods	10	40%
	Dysmenorrhea	9	36%
	Abdominal pain	5	20%
	Fever	0	0%
	Headache	0	0%
	White discharges	12	48%
	Dissatisfaction	0	0%
	Expulsion of the device.	0	0%
	Backache	10	40%
	Needs regular checkups	6	24%

Subjects were free to give more than one response

TABLE -10

Frequency and percentage distribution showing problems faced after having tubectomy

n=10

S. NO	PROBLEMS FACED	FREQUENCY	PERCENTAGE
6.	**Tubectomy**		
	Weakness	6	60%
	Depression.	0	0%
	Unexplained vaginal bleeding	2	20%
	.		
	Hernia	0	0%
	Abdominal pain/ cramping	4	0%
	Hypertension.	0	0%
	Breast tenderness.	4	40%
	decreased sexual desire	3	30%

Subjects were free to give more than one response.

SECTION –IV

Findings Related To Knowledge

TABLE 11

Mean, mode, median and standard deviation of knowledge score of married women regarding various contraceptive devices.

n=100

VARIABLES	RANGE OF THE SCORE	MEAN	MEDIAN	MODE	SD
KNOWLEDGE	14-44	24.96	24	21	5.42

Maximum possible score =55

LEVEL OF KNOWLEDGE OF SAMPLE SUBJECTS
TABLE-12

Frequency and percentage distribution showing level of knowledge.

n=100

Variables	Frequency	Percentage
Adequate	1	1%
Inadequate	99	99%

Adequate knowledge= ≥ 75%
Inadequate knowledge= ≤75%

SECTION –V

Chi square value showing association between knowledge score and selected factors

TABLE- 13
Chi Square Showing Relationship between Age and Knowledge score

n=100

S.NO	Selected Variables	Knowledge score		X2	df	Significance
		Below Mean	Above Mean			
1.	Age < 30 > 30	20 29	30 21	3.71	3	NS

$X2$ (3) =7.81, p ≥ 0.05

The data in table 13 shows the computed chi- square values (3.71) to establish relationship between age and knowledge score was found to be insignificant at 0.05 level of significance. Thus the result indicated that knowledge score had no relationship with age.

TABLE- 14
Chi Square Showing Relationship between Education and Knowledge score
n=100

S.NO	Selected Variables	Knowledge score		X2	df	Significance
		Below Mean	Above Mean			
2.	Education Illiterate Literate	24 27	16 33	29.4	4	S

X2 (4) = 9.4, p ≥ 0.05

The data in table 14 shows the computed chi- square values (29.4) to establish relationship between education and knowledge score was found to be significant at 0.05 level of significance. Thus the result indicated that knowledge score has relationship with education.

TABLE- 15
Chi Square Showing Relationship between Occupation and Knowledge score
n=100

S.NO	Selected Variables	Knowledge score		X2	df	Significance
		Below Mean	Above Mean			
3.	Occupation Employed Unemployed	8 40	21 30	38.09	3	S

X2 (3) =7.81, p ≥ 0.05

The data in table 15 show the computed chi- square values (38.09) to establish relationship between occupation and knowledge score was found to be significant at 0.05 level of significance. Thus the result indicated that knowledge score has relationship with education.

TABLE- 16

Chi Square Showing Relationship between Family Type and Knowledge score
n=100

S.NO	Selected Variables	Knowledge score		X2	df	Significance
		Below Mean	Above Mean			
4.	Family type Nuclear Joint Extended	20 17 13	22 15 13	0.16	2	NS

X2(2) = 5.9, p ≥ 0.05

The data in table 16 show the computed chi- square values (0.16) to establish relationship between family type and knowledge score was found to be insignificant at 0.05 level of significance. Thus the result indicated that knowledge score had no relationship with family type.

TABLE- 17

Chi Square Showing Relationship between Income and Knowledge score

n=100

S.NO	Selected Variables	Knowledge score		X2	df	Significance
		Below Mean	Above Mean			
5.	**Income** **<10,000** **>10,000**	27 22	18 33	4.9	3	NS

X2 (3) =7.81, p ≥ 0.05

The data in table 17 show the computed chi- square values (4.9) to establish relationship between income and knowledge score was found to be insignificant at 0.05 level of significance. Thus the result indicated that knowledge score had no relationship with income.

TABLE- 18
Chi Square Showing Relationship Between No. of living children And Knowledge score

n=100

S.NO	Selected Variables	Knowledge score		X2	df	Significance
		Below Mean	Above Mean			
6.	**No. of living children** **> Two** **< Two**	11 43	15 31	4.03	3	NS

X2 (3)=7.81, p ≥ 0.05

The data in table 18 show the computed chi- square values (4.03) to establish relationship between No. of living children and knowledge score was found to be insignificant at 0.05 level of significance. Thus the result indicated that knowledge score had no relationship with No. of living children.

4. CONCLUSION

The following conclusions were drawn on the basis of the findings of the study:

1. Only 1 subject is having adequate knowledge were as 99% have inadequate knowledge
2. The education, occupation, have significant relationship with knowledge score but there is no significant relationship between age, income, no. of living children , type of family and knowledge score of married women using various contraception methods at 0.05 levels.
3. Maximum problems were reported by the married women after using copper-T and minimum problems with Tubectomy.

5. RECOMMENDATIONS

1. Similar studies should be replicated on larger samples to validate the findings and make generalizations.

2. A study can be conducted to know the existing role of nursing personnel regarding family planning services can be determined.

3. Similar studies can be conducted taking other factors like sex, religion and other socio cultural factors as independent variables.

4. A comparative study can be conducted to find out the knowledge, preferences and problems faced by married women in rural and urban settings regarding various contraceptive devices.

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