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STUDY OF SOCIODEMOGRAPHIC PROFILE OF CONTRACEPTIVE USERS IN AN URBAN SLUM OF BIJAPUR

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ABSTRACT

Background: The fruits of economic growth cannot be felt unless population explosion is prevented. The contraceptive usage in community depends on various factors like socioeconomic class, religion, education, parity, preference for male children etc. The study was done to know the sociodemographic profile of contraceptive users. **Objective:** To assess the prevalence of contraceptive usage and to find out reasons for non acceptance. **Methodology:** community based cross-sectional study of the married women residing in an urban slum of Bijapur. **Results:** couple protection rate was 65.3%. Tubectomy (56.6%) was most common method of contraception. Contraceptive usage was more in families where women were from upper class, nuclear family, higher age group, high parity and had sons. These associations were found to be statistically significant. 34.7 % women were non acceptors of contraception. The most common reason for non acceptance was pregnancy & lactation (34.6%) and intending for more children (24.1%). Other important reasons were fertility related reasons, Opposition to use, Lack of awareness, and Fear of side effects. **Conclusion:** Contraceptive usage in community can be increased by improving IEC activities and quality of family planning services.

Keywords: sociodemographic profile, contraceptives, family planning.

INTRODUCTION

An Expert Committee (1977) of the WHO defined family planning as "a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country"¹. The population growth rate in India is alarming and detrimental to development of country. The fruits of economic growth cannot be felt unless population explosion is prevented. According to the census 2001, the Indian population was 1024 million and is expected to overtake China and

become the most populous country in the world by 2045.² India was the first country in the world to formulate the National Family Planning Programme in year 1952 with objective of "reducing the birth rate of the extent to stabilize the population at a level consistent with the requirement of National Economy"³. The contraceptive usage in community depends on various factors like socioeconomic class, religion, education, parity, preference for male children etc. The study was done to know the sociodemographic profile of contraceptive users and also to find out reasons for non acceptance.

MATERIALS AND METHODS

This is a community based cross-sectional study. The study was conducted on married women (15yr – 49yr) residing in an urban slum of the field practice area of Shri B M Patil Medical College. Sample size was calculated using the formula⁴ $Z = 4PQ / D^2$ as 258 (NHFS-3⁵, prevalence (P) of Family Planning practices in Karnataka for urban population was 60.8 %, at 5 % significance, with 10 % allowable error). The total sample size was rounded off to 300. The participants were interviewed using a pre-designed, structured questionnaire and data was

analysed by statistical tests like proportions & chi-square.

RESULTS AND DISCUSSION

It was observed from the study that majority women were Hindus (71.3 %) and Muslims were 28.7%. Most women were in the age group of 20-29yrs (29.6%) and from joint family (59%). As the study was conducted in slum, majority women (62.3%) were from lower socioeconomic strata (upper Lower and Lower class of Modified Prasad Classification).

Table I: Distribution of the study subjects according to the method of contraception

Method	Frequency	Percent
Condom	17	8.7
IUD	32	16.3
OCP	36	18.4
Tubectomy	111	56.6
Total	196	100.0

The couple protection rate in study area was 65.3% with 196 contraceptive users. The 34.7% women were not using any form of modern contraception. The contraceptive prevalence in study area (65.3%) was more than that observed by NFHS-3 for urban population in Karnataka (60.8%). Tubectomy (56.6%) was most common method of contraception. This was followed by methods like OCP (18.4%), IUD (16.3%) and Condom (8.7%). None of subject's partner had undergone Vasectomy as a method of contraception. A study in rural

community of Maharashtra⁶ observed the prevalence of contraceptive usage of 66.7 % with tubectomy as most common method of contraception. Anju Puri et al⁷ reported 58.3% of contraceptive users had tubectomy and vasectomy was not accepted by any of subject's partner. These studies indicate male dominant nature of society with family planning as a female domain. Thus there is need to encourage male participation (condoms, vasectomy) and improve couple protection rate.

Table II: Reasons given by those who did not want / need contraception

Reason	Frequency	Percent
Pregnancy /Lactation	36	34.6
Wants more children	25	24.1
Fertility related reasons	12	11.5
Opposition to use	15	14.4
Lack of awareness	10	9.6
Fear of side effects	6	5.8
Total	104	100.00

It was observed that 34.6% of women were either Pregnant or Lactating and hence not using any contraception. Intenders for children accounted for 24.1%. The other reasons for non acceptance were Opposition to use (14.4%), Fertility related reasons (11.5%), Lack of awareness (9.6%), Fear of side effects (5.8%). Khokhar A⁸ et al reported in their study reasons for non acceptance as anti religion, opposition

from family members, ignorance about use and no knowledge about the source. These studies indicate that many subjects had given the reason for not using contraception as lack of information, worry of side effects and opposition to use. These couples need to be properly counseled to reduce the myths & fear about contraceptives and improve acceptance rates.

Table III: Age structure and contraception use

Age	Acceptors	Non Acceptors	Total
15-19	2(5.6%)	34 (94.4)	36(100%)
20-24	15(35.7%)	27 (64.3)	42(100%)
25-29	26(55.3%)	21 (44.7)	47(100%)
30-34	35(72.9%)	13 (27.1)	48(100%)
35-39	51(85%)	9 (15)	60(100%)
40-49	67(100%)	0	67(100%)
Total	196(65.3%)	104(34.7%)	300(100%)

Chi square=122.16, df =5 p <0.000 1

The age of women had an influence on acceptance of contraception. The acceptance rate increased with increase in age of women. This

association was highly significant (p<0.0001). Sumedha M Joshi⁹ et al and Padma Mohanan¹⁰ et al reported similar findings in their studies.

Table IV: Religion and contraception use

Religion	Acceptors	Non Acceptors	Total
Hindu	144(67.3%)	70(32.7%)	214(100%)
Muslim	52(60.5%)	34(39.5%)	86(100%)
Total	196(65.3%)	104(34.7%)	300(100%)

Chi square=1.26, df=1 p =0.261

The acceptors of family planning were more in Hindus (67.3%) compared to Muslims (60.5%). However the difference was not statistically significant ($p > 0.05$). DHS reports⁸ from Bangladesh, Nigeria, Pakistan, Senegal and

study by Padma Mohanan¹⁰ et al have shown Muslims were less likely to be ever users. The non acceptors are more in Muslims may be due to religious objections.

Table V: Distribution of family planning practices and type of family

Type of family	Acceptors	Non Acceptors	Total
Joint	106(59.9%)	71 (40.1%)	177(100%)
Nuclear	90(73.2%)	33(26.8%)	123(100%)
Total	196(65.3%)	104(34.7%)	300(100%)

Chi square =5.65, df=1 p =0.017

Acceptors of contraceptives were more from the nuclear families (73.2%) compared to joint families (59.9%) and this association was statistically significant ($P < 0.05$). Sumedha M.Joshi⁹ et al cited a positive association

between nuclear family and acceptance of contraception. These studies indicate nuclear families may have better freedom of making decision and privacy compared to joint families.

Table VI: Socioeconomic status and contraception use

Socioeconomic status	Acceptors	Non Acceptors	Total
I Upper	16(84.2%)	3 (15.8%)	19(100%)
II upper Middle	21(80.8%)	5 (19.2%)	26(100%)
III lower Middle	49(72.1%)	19 (27.9%)	68(100%)
IV upper Lower	66(57.4%)	49 (42.6%)	115(100%)
V Lower	44(61.1%)	28 (38.9%)	72(100%)
Total	196(65.3%)	104(34.7%)	300(100%)

Chi square=10.85, df=4 p =0.028

Acceptors were more in upper class (84.2%) compared to lower class(61.1%) and there was statistically significant relation between Socioeconomic status and contraceptive use (P

< 0.05). These findings were similar to those reported by Bratati Bannerjee's¹¹ et al.

Table VII: Number of living children and contraception use

Living children	Acceptors	Non Acceptors	Total
0	4(22.2%)	14 (77.8%)	18(100%)
1	52(54.8%)	43 (45.2%)	95(100%)
2	82(70.7%)	34 (29.3%)	116(100%)
3	30(79%)	8 (21%)	38(100%)
>4	28(84.9%)	5 (15.1%)	33(100%)
Total	196(65.3%)	104(34.7%)	300(100%)

Chi square =29.61, df=4 p <0.00001

The number of children in family had positive influence on contraceptive use. Non acceptance decreased from 77.8% at zero parity to less than 15.1% in those having more than four children. This association was statistically highly significant ($p < 0.05$). A study in Calcutta

showed that women become more interested in controlling fertility after the birth of the first child and this increased with each additional child ¹². A similar study in urban slum of Mumbai showed CPR increased with increase in number of living children ⁹.

Table VIII: Number of Male children and contraception use

Male children	Acceptors	Non Acceptors	Total
0	24(36.9%)	41 (63.1%)	65(100%)
1	59(53.1%)	52 (46.9%)	111(100%)
>2	113(91.1%)	11(8.9%)	124(100%)
Total	196(65.3%)	104(34.7%)	300(100%)

Chi square =66.87, df=2 p <0.0001 significant

It was found that the acceptors of contraceptives increased with increase in number of male living children and association was statistically highly significant ($P < 0.0001$). The studies by Kansal Chandra ¹³ et al and Sharma AK ¹⁴ et al also cited want of male children in family as a reason for non acceptance of contraception. These studies indicate affinity for male child (male child syndrome) in society.

CONCLUSION

The pattern of contraceptive use in study area was similar to those observed by other studies in India and other developing countries. The people should be made aware of ill effects of population explosion. Importance of contraceptive use to space and limit births needs to be stressed. There is need to make programmatic changes in family planning services to encourage male participation. Economic development is the best contraceptives. Proper counseling can dispel myths about adverse effects. Interventions from religious leaders help in reducing religious differentials in usage of contraception. Women empowerment minimizes male child preference. Improving quality and basket approach to family planning services will improve the coverage.

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