

Married Women Practice and Attitude Toward Contraceptive Methods: A Cross-Sectional Study

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Abstract

Background: Married women's practices and attitudes toward contraceptive methods are intertwined and play a vital role in shaping their reproductive health choices. Attitudes reflect their beliefs, opinions, and evaluations of contraception, while practices encompass the actual use and adherence to contraceptive methods. **Materials and Methods:** Study design is descriptive cross-sectional study. About 400 women who are married have been chosen. Three parts of the questionnaire have been used; the first is sociodemographic information part, the second part is the Contraception Attitude Scale (CAS) to check attitude, and the third part is a constricted questionnaire to check married women's practice regarding contraceptive methods. All participants have been told about the aim of the study in detail and how this study is a stepping stone in the family planning in general. Nonprobability purposive sampling techniques were used to better representation of the target population (married women). **Results:** Attitude levels of women toward contraceptive methods with neutral attitudes from 62.8% of the total women count, followed by negative attitude level with percent (28.8) and the married women's practice levels were about 67.3% of them was poor, whereas only about 32.8% had good practice level. There is a highly significant relationship between attitude and practice level with *P* value of 0.002, and according to the relationship between practice levels and demographic data variables, the only significant relationship is between practice levels and age of married women with *P* value of about 0.042. **Conclusion:** Married women's level of practice regarding contraceptive methods was poor which may be due to the low educational level which is an important indicator of the miss use of contraceptive methods and unexpected pregnancy situations, also attitude levels of married women are natural, which means most of the married women of the study were having moderate attitude regarding contraceptive methods and there is a high relationship that is significant between practice and attitude which means attitude have an effect on practice and vice versa. By checking attitude and practice relationship with demographic data only one point was concluded which is the significant relationship between the practice level of married women and age groups.

Keywords: Attitude, contraceptive methods, married women, practices

INTRODUCTION

Contraceptive methods play a critical role in family planning, allowing couples to make decisions that are informed about the spacing and timing of pregnancies. Among married women, the practice and attitude toward methods of contraception are determined by a multitude of factors, including cultural norms, religious beliefs, socioeconomic status, education, and access to healthcare services.^[1] Studying and analyzing these factors is essential for constructing effective family planning plans and interventions tailored to the specific needs of married women.^[2]

The practice and attitude toward contraceptive methods among married women have significant implications for reproductive health, family planning, and overall well-being.^[3] Contraceptive use enables married women to make informed decisions about the timing and spacing of pregnancies, empowering them to pursue education, career goals, and ensure a better quality of life for

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themselves and their families.^[4] However, the adoption and utilization of contraceptive methods are determined by a complex interplay of individual, social, and structural factors.^[5] Understanding the practice and attitude toward contraceptive methods among married women is vital for constructing effective family planning programs, policies, and interventions. It allows policymakers, healthcare providers, and researchers to identify barriers, tailor interventions, and promote the use of contraception as a means of promoting reproductive health and achieving sustainable development goals.^[6]

The attitudes of married women toward contraception are shaped by a variety of factors. Religious norms and cultural norms play an important role in influencing perceptions and acceptance of contraceptive methods, as they often intersect with beliefs about gender roles, fertility, and the sanctity of marriage.^[7] Societal pressures and expectations related to family size and reproductive choices may impact the decision-making process and create barriers to accessing and using contraceptives.^[8]

Moreover, factors that are individual like education, knowledge about methods of contraception, socioeconomic status, and empowerment play important roles in shaping attitudes toward contraception.^[9] Educated women tend to have better access to information, enabling them to make informed decisions and overcome barriers related to contraception.^[10] Economic factors, including affordability and accessibility of contraceptive methods, influence the choices available to married women and their ability to maintain consistent use.^[11]

Communication and spousal dynamics within the marital relationship also impact contraceptive practices.^[12] Open and supportive communication between partners can facilitate joint decision-making and increase the likelihood of contraceptive use. Conversely, power imbalances, lack of communication, and gender inequalities may hinder the adoption of contraception.^[13]

The practice of contraceptive methods among married women is influenced by the availability and accessibility of healthcare services.^[14] The presence of reliable and affordable contraceptive methods, access to healthcare facilities, and quality of counseling services are critical determinants of contraceptive use. Lack of access to contraception, limited availability of methods in certain regions, stigma, and inadequate healthcare infrastructure can pose significant barriers to contraceptive uptake and continuation.^[15]

In recent decades, there has been a significant shift in attitudes toward contraceptive methods among married women.^[16] Traditionally, cultural and societal norms often associated contraception with negative connotations or taboos, leading to limited awareness and utilization of contraceptive options. However, with increasing education

and awareness campaigns, along with advancements in medical technology, attitudes have started to change.^[17]

Today, many married women view contraception as an essential tool for family planning, allowing them to exercise autonomy over their reproductive decisions. It enables couples to determine the number of children they desire, the spacing between pregnancies, and the overall timing of childbearing.^[18] By offering greater control over fertility, contraceptive methods empower women to participate actively in educational, professional, and social endeavors while balancing their family responsibilities.^[19]

Furthermore, the practice of contraceptive methods among married women has proven to have significant positive impacts on public health. It helps to reduce maternal and infant mortality rates by preventing unintended pregnancies and high-risk pregnancies.^[20] Additionally, it contributes to improved maternal and child health outcomes, as women can better plan their pregnancies, seek appropriate antenatal care, and ensure a healthy start for their children.^[21]

However, it is important to acknowledge that attitudes and practices regarding contraceptive methods can still vary widely across different regions and cultures. Factors such as religious beliefs, cultural norms, socioeconomic status, and access to healthcare services can influence the acceptance and utilization of contraceptive options.^[1] Thus, addressing these contextual factors and promoting comprehensive sexual and reproductive health education is crucial to ensuring that all married women can make informed choices and access the contraceptive methods that best suit their individual needs and preferences.^[10]

MATERIALS AND METHODS

Research design

A descriptive cross-sectional study design was carried out to attain the stated objective. It was conducted to identify married women's practice and attitude levels toward different types of contraceptive methods.

Study sample and setting

There were 400 married women who participated in the study. They were choosing carefully used the purposive sampling method from three healthcare centers at Al Rifai primary health care centers (Sayd Al Shuhada Primary Healthcare Center, Al Rifai Primary Healthcare Center, and Al Hakeem Primary Healthcare Center). About 2 months data were collected. The inclusion criteria were women less than 46 years old, women older than 15 years old, and women who are free of mental health disorders, while exclusion criteria were women younger than 15 years old, women older than 45 years old, and women with mental health problems. The sample size was determined

by a specific equation for this type of study $\frac{z \times pq}{d}$.

p refers to the estimated proportion of outcomes that is expected regarding to relevant studies (if they were found) as used in the same study, if there were no previous relevant studies probability rule can be used which is $50\% = 50\%$. z represents the level of confidence 95%, so, the $z \rightarrow 1.96$. d represents the level of desired significance, which is 0.05. q is $(1-p)$ 0.729.

Instrument of the study

The instrument of the study consists of three parts:

First: Demographic variables such as age, age at time of marriage, parity, residency, monthly income, educational level, and occupation.

Second: Practice scale, according to the practice questionnaire and after reviewing relevant papers practice scale is constructed. Their answer was yes and no, yes taking 1 and no taking 0, except for the negative items (item 2, item 5, item 9, and item 10), a lower score indicates poor practice and a higher score indicates good practice, the minimum score is 0 and maximum score is 10 so practice levels are 0–5 = poor practice, and 6–10 = good practice. In addition, two more questions were added to the practice part to investigate two information: the first is to explore what is the contraceptive method used in the last unintended pregnancy, and the second question is to explore what is the reason that may prevent married women from using contraceptives both questions referred as sociodemographic information but inserted in practice part to get in line with the context of practice questions. The original instrument was in English language then it has been translated in two ways: first, it was translated forward to Arabic language then it was translated backward to English language, Questionnaire was measured for its validity by giving it to eight experts and taking their opinions and suggestions, in addition, reliability of the instrument was done by using Cronbach α test for the practice scale, which the result was 0.88 and it is accepted value.

Third: Contraception Attitude Scale (CAS) form involves 32 items 17 items are positive items and 15 items are negative items to which participants indicate their agreement or disagreement. It was originally generated by Brown in 1984 to measure attitudes toward contraceptive methods.^[22] A modification has been made by deleting two items which they cannot fit or be accepted by the norms of the Iraqi people so the items become 30 items only. It is self-reported and it is used commonly for contraception attitude. The CAS was originally designed in English and after that, it has been translated into many different languages because it was effective at measuring the intended construct. Items of the CAS Scale are measured on a 5-point Likert scale, starting with strongly disagree which is equal to 1, and grading till strongly agree, which is equal to 5; except for the negative items (1, 2, 4, 7, 8, 9,

11, 13, 14, 15, 17, 24, and 29) they mean their answer is reversed by the meaning, which they are scored reversibly (strongly disagree, which is equal to 5) grading till (strongly agree, which is equal to 1), the higher scores indicating higher attitude level.^[23] The scores that are minimum a student can get on the CAS is 30 and the maximum score is 150 points. Three attitude levels were identified among married women (negative, neutral, and positive attitude). These levels were determined based on the sum of scores method (Maximum – Minimum/ N “number of attitude levels”). Therefore, the attitude formula is $(150 - 30/3)$; accordingly, the levels are identified as follows: 30–70 “negative attitudes”; 71–110 “neutral”; 111–150 “positive attitudes.”

Ethical approval

The study protocol and the subject information and the consent form were reviewed and approved by a local ethics committee and no. 3226 (September 26, 2022).

RESULTS

Table 1 shows the sociodemographic characteristics of the married women ($N = 400$). About half of the participating women's (42.3%) age ranges from 23 to 28. Also, more than half of them (56.5%) are married at ages between 20 and 25. About two-thirds of the women (74.3%) have 1–3 children. In addition, the economic status as it is considered enough, barely enough, or not enough per month for 64.8% of them was enough per month. Moreover, 85.8% of the married women live in rural areas with 21.5% of them with a bachelor's degree as an educational level followed by a diploma degree with about 21% of the total participants and more than two-thirds of them (68%) are not working and have no job.

Table 2 describes the contraceptive methods used by married women in the last unexpected pregnancy which shows the withdraw method was the highest followed by oral contraception pills.

Table 3 findings present the practice level of contraceptive methods among married women. The higher percent is poor practice which constitutes about two-thirds of the results. These results are further illustrated in Figure 1.

Table 4 reveals the attitude levels of married women about contraceptive methods with neutral attitudes (62.8%) of the total women followed by negative attitude level in percent (28.8%).

Table 5 indicates the relationship between attitudes and women's practices. Married women's practices have a significant relationship with their attitudes, which means practices and attitudes are affected by each other too.

Person Chi-square analysis was used to find the association between practice level and age groups of married women.

Table 1: Sociodemographic characteristics

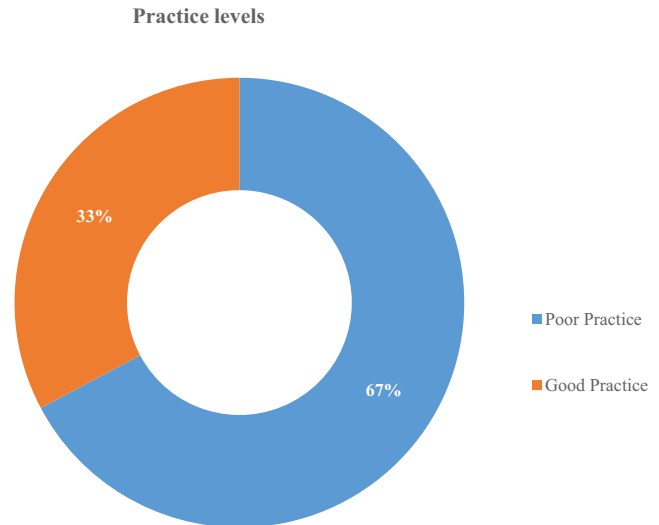
Sociodemographic data	Frequency	Percent (%)
Age groups		
16–22	42	10.5
23–28	169	42.3
29–33	107	26.8
34–39	48	12
40 and older	34	8.5
Total	400	100
Age at marriage		
Under 20 years	144	36
20–25 years	226	56.5
26–30 years	27	6.8
More than 30 years	3	0.8
Total	400	100
Births number		
No births	4	1
1–3 births	297	74.3
4–6 births	97	24.3
More than 6 births	2	0.5
Total	400	100
Monthly income		
Not enough	20	5
Barely enough	121	30.3
Enough	259	64.8
Total	400	100
Living address		
Urban area	57	14.3
Rural area	343	85.8
Total	400	100
Education levels		
Does not read and write	55	13.8
Read and write	76	19
Primary education	47	11.8
Secondary education	38	9.5
Diploma degree	84	21
Bachelor degree	86	21.5
Postgraduate (Master or PhD)	14	3.5
Total	400	100
Work status		
Working	128	32
Not working	272	68
Total	400	100

Table 2: Descriptive statistics of contraceptive methods have been used with the unexpected pregnancy

Used contraceptive	Frequency	Percent (%)
Condom	5	1.3
Oral contraception pills	28	7
Contraceptive injection	2	0.5
Rhythm method	22	5.5
Withdraw	39	9.8
No method	304	76
Total	400	100

Table 3: Married women practice levels

Practice levels	Frequency	Percent (%)
Poor practice	269	67.3
Good practice	131	32.8
Total	400	100.0


Figure 1: Women's practice level

The findings of Table 6 explain that there is an association between practice level and age groups ($P < 0.05$).

DISCUSSION

The current study was made by taking information from 400 women who live in Al Rifai City both rural and urban areas, all women were married. After testing their practice, the result was pointing to poor level practice, this result was for 67% of women which is about two-thirds of the participants. Many factors could lead to such results like low knowledge about contraceptive methods which is the most common cause of such results, and, in this study, we could find that educational levels of married women were low and below secondary degree for more than half of them, what supporting these findings is a study of Tilahun and Dinkinesh, 2021 which they found that good and safe practices among participated women are related to high and good knowledge about contraceptive methods and the women were showing that about half of them having an educational degree above secondary educational degree.^[24]

To get more in-depth with discussing poor practice reasons, poor contraceptive practices among married women can be multifaceted and context-specific. Like limited access to contraceptives, that is, women may have limited access to contraceptive methods due to geographical, financial, or other barriers. This may result in a lack of consistent use or use of ineffective methods.^[25,26]

Regarding the relationship between practices and demographic variables in this study, there was only one relationship that is, significant, which is between practice levels and age, and there was no other relationship.

However, age has a strong relationship with practice, two sides to this relationship, first, younger women tend to be less confident about contraceptive methods, and they are much more worried than older women about being pregnant or not, also it has been found that younger women need social support from older age women to use contraceptive methods, Young women experience intense pressure to become pregnant and have babies after marriage as soon as possible to demonstrate their reproductive potential; giving birth at a young age and at intervals that is short are common variables that jeopardize the mother health and babies.^[27-29]

Study of Arbab *et al.*^[30] also found that there is a significant relationship between women's practices and their ages, older women tend to use contraceptive methods at ages 30 and above as they start to have a burden and have more experience with pregnancy and contraceptive methods, because when they are younger and at the early

in marriage they think that being pregnant is a matter of God and the number of children is something in God's hand, and for that Arbab *et al.*^[30] had recommended a counseling session.

Another study proposing another idea, Imtishal *et al.*^[31] mentioned, the older individuals had fewer practice values compared to a younger age group, which might explain why they became pregnant again later in life. One probable explanation is that older women have greater experience using contraceptive techniques than younger ones. Married women between the ages of 40 and 49 are four times more likely to utilize contraception. Furthermore, Ismail *et al.*^[32] discovered that contraceptive use declines beyond the age of 40.

Married women's attitude levels in this study are neutral, as about 62% of married women have this level among the participants. This result does not agree with the result of Dhakal *et al.* as they found that positive attitude is common level among the participants, different reasons could cause these differences in results, firstly, it may due to the difference in scale have been used by Dhakal which was constructed by the researcher and contains no negative questions; moreover, the geographical area and the nature of society which is much different between this study and Dahkal study.^[33]

According to the married women's neutral attitudes toward contraceptive methods, there are several potential reasons that could result in such results; lack of knowledge is an important reason actually, some women may not be familiar with the various types of contraceptives available to them and may not have had access to comprehensive sexual education.^[34]

Also, other factors like religious or cultural beliefs,^[35] partner's attitudes,^[36] and personal preferences are affecting directly on women's attitude levels.^[37] This study has checked all possible relations with demographic data but there was no relationship between attitude and demographic data.

Relationship between attitude and practice has been found to be significant, which means there is a relationship between the two variables. The strong relationship between attitudes and practices regarding contraceptive methods

Table 4: Married women's attitudes

Attitude levels	Frequency	Percent (%)
Negative attitudes	115	28.8
Neutral attitudes	251	62.8
Positive attitudes	34	8.5
Total	400	100.0

Table 5: Relationship between attitudes and practice

Correlations	Women attitudes	Women practices
Attitudes		
Pearson correlation	1	0.152*
Sig. (2-tailed)		0.002
N	400	400
Practices		
Pearson correlation	0.152**	1
Sig. (2-tailed)	0.002	
N	400	400

*Correlation is significant at the 0.01 level (2-tailed)

Table 6: Association between practice levels and age groups

Age groups	Practice levels		Total	Pearson Chi-square		
	Poor practice	Good practice		Value	df	Exact sig. (2-sided)
17-22	31	11	42	9.921 ^a	4	0.042
23-28	118	51	169			
29-33	74	33	107			
34-39	31	17	48			
40 and older	15	19	34			
Total	269	131	400			

^a0 cells (0.0%) have expected count less than 5. The minimum expected count is 11.14

among married women is a complex and multifaceted one. Attitudes refer to the beliefs, opinions, and evaluations that individuals hold, while practices encompass the actual behaviors and actions, they engage in.^[38]

Attitudes play a crucial role in shaping individuals' contraceptive practices. A positive attitude toward contraception indicates a willingness to adopt and use contraceptive methods effectively. Conversely, negative attitudes can lead to non-use or inconsistent use of contraceptive methods. Attitudes are affected by a variety of factors, including cultural, religious, social, and personal beliefs.^[39]

Religious beliefs also cultural beliefs often play a role that is significant in forming attitudes toward contraception. Some cultures and religions may have conservative views that discourage or prohibit the use of contraceptives. In such cases, married women may hold negative attitudes toward contraception, considering it morally or religiously unacceptable. These attitudes can significantly impact their contraceptive practices, leading to non-use or reliance on traditional or less effective methods.^[40]

Social factors, such as peer influence, family norms, and societal expectations, also affect attitudes toward contraception. If married women perceive contraception as socially acceptable and encouraged by their immediate social circle, they are more likely to have positive attitudes and engage in consistent contraceptive practices. Conversely, societal stigma or pressure to conform to traditional gender roles may create negative attitudes toward contraception, resulting in lower usage.^[41]

Personal factors, including education, knowledge, and access to information, also influence attitudes and practices regarding contraceptive methods. Well-informed women with access to comprehensive sexual and reproductive health education are more likely to have positive attitudes toward contraception. Imtishal *et al.* found the same result and agree with this information as they mentioned women's education levels and their poor knowledge in addition to the easiness to get information about contraceptive methods are a strong determinant of women's attitudes and practices toward contraceptive methods.^[42]

However, it's important to note that attitudes alone do not always translate into actual practices. Various barriers and challenges can prevent married women from using contraception consistently, even if they hold positive attitudes. These barriers may include limited access to contraceptive services, lack of information, financial constraints, fear of side effects, partner opposition, or inadequate support from healthcare providers.^[43]

To address the relationship between attitudes and practices, interventions and programs should focus on multiple levels. Comprehensive sexuality education, targeted awareness campaigns, and culturally sensitive

counseling can help promote positive attitudes toward contraception. Efforts should also be made to improve access to a wide range of contraceptive methods, address social and cultural barriers, involve partners in decision-making, and provide ongoing support and follow-up to married women.^[44]

Attitudes play a significant role in shaping contraceptive practices among married women. Positive attitudes are more likely to lead to consistent and effective use of contraception, while negative attitudes may result in non-use or reliance on less reliable methods. Understanding and addressing the complex interplay between attitudes and practices is crucial for promoting reproductive health and empowering married women to make informed decisions about contraception.^[3]

CONCLUSIONS

Practices of married women toward contraceptive methods are poor that may due to low educational level which is an important indicator of the miss use of contraceptive methods and unexpected pregnancy situations, also attitude levels of married women are natural, and there is a relationship that is highly significant between practice and attitude which means attitude have an effect on practice and vice versa. By checking attitude and practice relationship with demographic data only one point was concluded which is the significant relationship between practice level of married women and age groups.

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Conflicts of interest

There are no conflicts of interest.

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