CHAPTER I

INTRODUCTION

1.1 Background

The world's population has doubled its size over the past forty years, reaching six billion in 1999. Although fertility rates are declining; another three billion individuals may be added to the global population over the next half-century (WHO,2000). Rapid population growth strains essential resources and impedes economic progress in developing countries. It has also clear implications for public health in terms of sustaining human health, which is a prime reason for concern about population growth and models of economic development.

Today 80% of world's people live in developing countries compared to 70% in 1960 (WHO, 2000). Access to family planning can promote women's health and reduce fertility and may delay the demographic transition in poor countries and potentiate future public health disasters (WHO, 2003). States that by the end of the decade there will be over six billion people, of whom one half will live in cities. These demographic and environmental trends, if translated into climatic change, regional food shortages, and weakened ecosystems, would adversely affect human health.

The health benefits of contraceptive use are significant. Contraceptives provide women with a safe and effective means to avoid unwanted pregnancies that may place

their health at risk. Unwanted pregnancies can have serious health consequences like illness, disability, and maternal death. Many of these deaths occur when women with unwanted pregnancies seek unsafe abortions. If all women who wanted no more children had access to and used effective contraception, an estimated 100,000 women's lives could be saved each year (WHO, 1997). Between 120 and 150 million of married women worldwide want to stop childbearing or to space their next pregnancy, yet they are not using any method of contraception. Lack of contraceptive use and contraceptive failure are the main cause of unintended pregnancy (Chichakli et. al., 2002). In many cases, women continue with their pregnancies, risking their health and well being, and the welfare of the families. The toll of maternal death and risk of unintended pregnancy are greatest in developing countries. WHO estimates that 99% of maternal death and about 95% of unsafe abortions are either due to lack of access to family planning or contraceptive failure. Among the reproductive age group in developing countries, morbidity pattern reveals that 18% of total burden of disease is caused by pregnancy related, 15.5% by sexually transmitted diseases and human immunodeficiency virus (HIV) and 2% by anemia.

There are vast discrepancies in access to reproductive health care between developed and developing world, urban and rural, educated and uneducated (WHO, 1998). The educated women know when to avail for the family planning services and they also know about the methods of contraception and its adverse effects and the service acceptance in good. On the contrary, the uneducated women are shy and lack knowledge on the types of contraceptive methods and availability in terms of time and places Most of the rural women will not avail for the contraceptive services due to

shyness and become pregnant. Since the sexual promiscuity is high, unwanted pregnancies are usually terminated through practice of unsafe abortions across borders since it is illegal in the country. For example in Africa many women are shamed of being poorly dressed in front of health workers and were also afraid that health workers would react negatively to their literacy (WHO, 1998). This type of feelings among the women deterred women from using the service. Unwanted pregnancies are still prevalent and no doubt lead to unsafe termination of pregnancy. It is a well-known fact that unwanted pregnancy and unsafe abortion can lead to health consequences like bleeding and anemia, septicemia and maternal death. The vulnerable groups comprising of adolescents, single women and women over 40 years of age are affected. Given their desperate situations with unwanted pregnancies some women opt for unsafe abortions leading to complications resulting in serious compromise on the health of the women that contributes to high maternal morbidity and mortality.

1.1.1 The Health Care System in Bhutan

Bhutan has a population of about 700,000 out of which 50% are women and 22.5% of these women are of reproductive age group and 90% of these are currently married. The present total fertility rate of Bhutan is 4.7, which is quite high according to the target set by the government where the target was to bring down the fertility rate to 3% or below by the year 2000, which is not, achieved yet.

Bhutan, with the introduction of modern medicine, life expectancy has increased from 46 years in 1977 to 66 years of age in 2000; similarly the under five mortality and maternal mortality have been seeing a downward trend since 1984

(National Health Survey, 2000). Between 1984 and 2000 the infant mortality is reported to have fallen from 102.8 to 60.5; the under five/infant mortality rate reduced from 162.4 to 84 per 100 live births; and the maternal mortality ratio from 770 to 258 per 100,000 live births, out of which 1.41% are from abortion and its complication. According to the annual health bulletin 2003, the percentage of women of reproductive age group using contraceptive devices is 30%, which is below the expected level.

A declining mortality rate and a stationary birth rate of 39.9 per 1000 population during the early 90s had resulted in a high population growth rate of 3.1% in 1994. This sudden rise awakened a surge of interest and debate in terms of its possible consequences. The Royal Government expressed serious concern over the issue and has emphasized the importance of population planning for eventual peace, prosperity and happiness of the people. Accordingly, the increased priority was given to the population planning in 8th five year plan, following which the growth rate has come down to 2.6% but till short of 2% targeted for the year 2002 (Department of Health Services, 2002). Increased fertility rate and unintended pregnancies are one of the direct causes of maternal mortality in Bhutan. The 8th five year plan also considers reproductive health (RH) crucial to general health and sees development of a strategy to focus on RH care with all its respective service components.

A youth guidance and counseling unit has been established to counsel and disseminate RH information to adolescents and youth. Efforts are also made to increase the literacy rate through adult education program Contraceptive services are provided through four-tiered network of health institutions. Those populations that cannot be

covered by static health facilities are reached by outreach clinics. Although the contraceptives services are made freely available throughout the country, there is still profound underutilization of these services with low prevalence rate of contraception. Even though the health service coverage is 90%, there are still undetached pockets, which lead to low utilization of the health services and contraceptive services. Distance and lack of transportation from the home to the health facilities is one of the problems, most of the rural people face.

More than 89% of the Bhutanese population lives in the rural areas. The distance from the village to motor able road varies from few hours to few days of walking (Ministry of Health & Education, 2000). The means of transportation in the rural areas are mainly by pony or walking. The rural areas of Bhutan are far away from the health centers or hospitals with the result that most women live five to six hours away from the nearest health center. The scarcity of vehicles with poor road conditions and limited decision-making power make it really difficult for women to reach to the health facilities to get the desired service. There is also a problem with the out reach clinics for the undetached as this service is conducted once a month, which causes inconvenience and contraceptive failures. If the population grows at the current rate it is predicted that the country's population would be doubled in next five years (Ministry of Health & Education, 2000). Increase in population will put undue strain on social sectors, unemployment opportunity, landholding and the quality of life as a whole.

There are many cultural and social barriers that still prevent women from being able to exercise their freedom of reproductive choices. In many parts of the world,

women's decision-making power is extremely limited, particularly in the matters of reproduction and sexuality. WHO (1998) states that, in the South East Asia, mother in laws, husbands or other family members make decisions about maternal care and family planning. In Nepal and in some parts of India the mother in-law attends most of the deliveries and 75% of the mother in-laws did not believe in antenatal check up and postnatal care and the decision for family planning are made either by husband or mother in-law (Kutzin, 2000)

Women's status in Bhutan

Women in Bhutan are treated equally and gender balance is maintained and women do not face many of the disadvantages faced by women in other developing countries. Women are involved in decision making in household and at the community level (United Nation International Children's Emergency Fund, 2000).

Wangdi P. (2002) States that, in the Bhutanese society, the status of the women is good in comparing to the rest of the South Asia. In Bhutan the women inherits land and all other assets, houses are headed by females. Bhutan has always provided a safety net for women and law has ensured equality amongst the gender. In Bhutan women has equal power with men in decision-making

1.1.2 Family Planning Service in Bhutan

The types of contraceptives methods available in Bhutan are oral contraception pills (oral pills), injection (DMPA), intrauterine devices (IUD) and male condom, but some rural community might be practicing the traditional methods of family planning.

All these methods are available from all the health centers and hospitals, and the service is provided free of charge. Despite these, the utilization of the contraceptive services is still low. Tubal ligation and vasectomy are also performed in the district hospitals and reinforced by conducting family planning camps at least once a year. No contraceptives are available in the market and everyone who needs the service obtains from the health facilities. Abortion is illegal in the country.

Punakha District

Of the 20 districts that compose Bhutan, Punakha is one among them located in the western zone. It has a population of 13,713 with 6,560 males and 7,153 females and 1,270 of the females are in the reproductive age group. There are 5 peripheral health centers and 1 district hospital. Each health center is has 3 trained staff comprising of 1 Health Assistant (HA), 1 Auxiliary Nurse Midwife (ANM) and 1 Basic Health Worker (BHW). Access to the health centers by road exists and remains opened throughout the winter period. Basic communication facility has also been installed. Communities residing at the far end from the health centers have to walk minimum of 4 to 5 hours to reach the health center for obtaining any services. Any health services as outlined for the national level are also uniformly made available throughout the district.

The villages in Punakha District are well connected by roads and there is health center in very village with the trained health worker to provide contraceptive services. All the family planning methods are available in every health center, but there is unknown prevalence of contraceptives use and lack of clarity in factors affecting the contraceptive usage among married women of reproductive age in Punakha. So far no

study has been done to assess the contraceptive usage in Punakha District. Therefore this study will provide baseline information on factors affecting contraceptive use in the District.

1.2 Rationale of the Study

There is little or no information regarding the prevalence of using family planning services and factors effecting contraceptive use among married women of reproductive age in Punakha District. Therefore this study is focused on identifying the prevalence of using contraceptives and related factors that affects the use of family planning service among the married women of reproductive age.

1.3 Research Question

1. What is the prevalence of contraceptives usage among married women of reproductive age (15-49years) in Punakha district?
2. What are the factors associated with the utilization of contraceptives among married women of reproductive age (15-49years) in Punakha district?

1.4 Objective of the Study

General objective

To find out the contraceptive prevalence rate, and the factors, effecting the utilization of the contraceptives among the married women of reproductive age (15-49 years) in Punakha District Bhutan.

Specific objectives

I. To describe the usage of contraceptives among married women of reproductive age

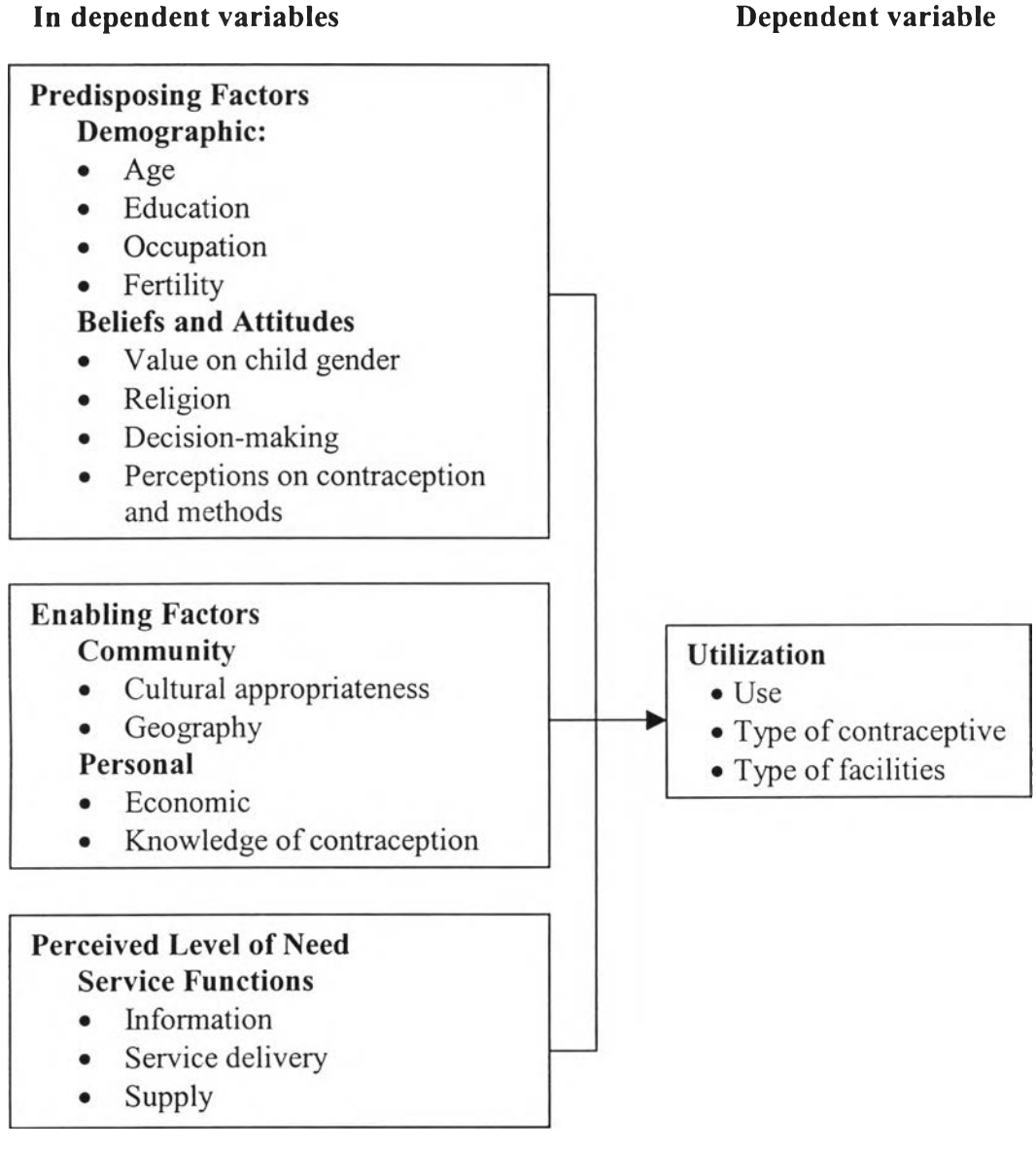
II. To describe predisposing factors (demographic characteristic and attitudes) of contraceptive usage among the married women of reproductive age

III. To describe enabling factors (community and personal) on contraceptive usage among married women of the reproductive age

1V. To describe perceived need of contraceptive among the married women of reproductive age group

V. To examine the relationship between utilization and predisposing factors, enabling factors and perceived need

1.5 Conceptual Framework of the Study: Factors Affecting Utilization of the Contraceptive Service



Source: Modified from Andersen 1995

Figure 1: Conceptual Framework of the Study: Factors Affecting Utilization of the Contraceptive Service

1.6 Scope of the Study

This study is done in Punakha among the married women of reproductive age (15-49 years), therefore it represents the married women of reproductive age of Punakha District and it is not representing for whole Bhutan

1.7 Variables Employed in the Study

Independent variables

Impendent variables include: Demographic factors like, Age, Occupation, Education, and Fertility. Beliefs and Attitudes: Value on child's gender, Religion, Decision making for Contraceptive use, and Perception on contraception and methods. Enabling factors and perceived need: Accessibility, Personal income, Knowledge on contraceptive, Availability of information and the contraceptives

Dependent variable

Utilization, type of contraceptives used and type of facilities used.

1.8 Operational Definitions of Terms Used in the Study

Table 1: Operational Definitions of Terms Used in the Study

Variables	Operational definition
Age	It is the age of the women from15-49 years. The age will be grouped from (15-19), (20-24), (25-29), (30-34), (35-39) and 40 and above and will be coded accordingly
Occupation	It means the current job of the women to earn their living: the job will be categorized as farming, housewife, day laborer, government servant and business. It will be grouped under each and category and will be coded.
Education	It means the literacy level of the women: it is divided into different categories, none when the person has not attended any form of educational institution. Non-formal education is form of education imparted to all women in basic reading and writing skills. Primary is standard six and below. Secondary is standard seven and eight, higher secondary is between standard nine and twelve, college/university after that. Each respondent will be grouped under these categories and will be coded.
Fertility	It is the number of living children the women have, and the number of the children will be grouped in the following way, (no living children), (1-2), (3-4), (5-6), and 6 and above
Value on child's gender	It means the family's preference to have boy or girl child in the family. A questionnaire will be developed regarding the liking for the child's gender.
Religion	It is the religion of the women, religion are specified as Buddhism, Hinduism, Christianity and other
Decision making	It means who make the decision for the women to use contraception, it is herself, husband, mother/ mother in laws, health workers, peers or husband and herself

Table 1: (Cont.) Operational Definitions of Terms Used in the Study

Variables	Operational definition
Perception on contraceptive methods	It means what is the women perception on the contraceptive methods, is it good, bad, harmful or useful etc. statement questionnaires will be developed to test this.
Cultural appropriateness	This is whether service provide are culturally appropriate to the women or not. Questionnaires will be developed regarding the cultural appropriateness and will be grouped
Geography	Geography here means the distance, travel time, type of transportation and the place of residence i.e. rural or urban
Economic*	Economic here means the income of the women, it is determined by the type of house, number of cows, vehicle, television etc.
Knowledge	It means the knowledge of the women regarding the contraception's and the different methods, questionnaires will be developed on the contraceptive methods to check the knowledge of the women
Information	It is the health information on contraceptives that the women need to know from the health worker
Service delivery	It means whether the women get the service she wanted from the health facilities whenever she visits the health center
Type of contraceptives used	It is the different methods of contraceptives that the women are using/ or practicing
Type of facilities	It means the facilities from where the women gets the contraceptives services, is it a hospital, health center or an out reach clinics

* Rationale for indirect assessment of economic status – Given the rural situation in Bhutan eventual existence of barter practices, indirect encashment of economic status was preferred in this study.