Knowledge and attitudes of rural women regarding family planning

Impressions based on interviews with antenatal clinic attendees and student-nurses at Rietvlei Hospital

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Summary

A questionnaire was designed and used to assess the ready knowledge and to probe the attitudes of rural antenatal clinic attendees (ANCs) regarding contraception. The survey revealed inadequate knowledge regarding the range of available methods and the potential side effects of artificial birth control. No support was found for the common assumptions that rural women regard children as a current economic asset, or that they regard grand multiparity as protection against the high rural infant mortality rate. The majority of the women showed a high degree of receptiveness to family planning, but lacked the freedom of choice in regard to the regulation of their own reproduction. This pointed to the need to extend family planning education to include rural men in whom vests the power of consent.

S Afr Fam Prac 1986; 7:169–74

Curriculum Vitae

DAN NCAYIYANA was born in Port Shepstone, Natal in 1939 and was raised in Durban. Following the interruption of his medical studies in the third year at the University of Natal, he subsequently entered the University of Groningen Medical School in the Netherlands, where he completed his Arts-examen in 1970. There he also met and married Klementine Molendijk, now the mother of their 5 children. Dr Ncayiyana then emigrated to the United States where he specialised in Obstetrics and Gynaecology at the New York University / Bellevue Hospital Medical Center in New York City (1970–1975), was certified by the American Board of Obstetrics and Gynaecology, and obtained his American Fellowship (FACOG). He then joined a group practice in Washington, doing Obs/Gynae with emphasis on infertility. After a 20-year sojourn abroad, Dr Ncayiyana and his family returned to Southern Africa in 1983 to join the Transkei Department of Health.

KEYWORDS: Family Planning; Contraception; Knowledge, attitudes, practice; Health Education; Rural Population

Although Transkei couples have ready access to contraceptives through a network of government-sponsored clinics and hospitals, contraceptive use remains limited and sporadic. In 1984 only 1 167 new clients sought and received birth control prescriptions from our clinics, which serve a community of over 100 000 (Table 1). Various psychosocial, cultural and economic explanations are often advanced for the apparently poor acceptance of family planning here and elsewhere in Africa. However, it has also been shown that ignorance of family planning methods can be an important constraint on contraceptive use despite ready availability[1]. This study was therefore conceived to obtain an impression of:

- the level of ready contraceptive knowledge,
- the attitude to birth control, and
- the extent of the 'freedom of choice'

in regard to the use of contraception of the women attending the antenatal clinic and of student-nurses at Rietvlei Hospital, and to see if differences existed between the village women and the nurses as a result of the higher formal educational level of the latter group.

Table 1

Family Planning Statistics

Umzimkulu District 1984

Method	First visit only		Total visits (include repeats)	
	No.	%	No.	%
BC Pills	689	59,0	2 993	66,6
D-Provera	401	34,4	1 418	31,5
Condoms	53	4,5	62	1,4
Tubal ligation	24	2,1	24	0,5
Totals	1 167	100,0	4 497	100,0

(G. Ter Haar, unpublished clinic records)

Subjects and methods

A questionnaire was drawn up (Table 2), consisting of 10 questions carefully phrased so as to minimise ambiguity, and interviewer and translation bias. The question called for spontaneous responses with minimal prompting. (This approach has been criticised[2] on the basis that spontaneous *and* prompted responses *together* more accurately reflect the level of knowledge. Our premise was that a woman's initial decision to seek contraception is influenced by her *ready* knowledge and attitude, rather than by a vague notion that crystalises on prompting).

The interviews were conducted by the authors and by appropriately instructed midwifery students, on 70 pregnant women attending the Rietvlei Hospital antenatal clinic in the Transkei district of Umzimkulu, in the order of queue as they presented themselves for antenatal screening, on the days when the interviews were conducted. Identical questions were also put to 33 nursing students constituting the second year of training, all of whom came from rural homes.

Table 2

Family planning questionnaire

1. How many children would you like to have, all told?
2. (a) What are the advantages of having many children?
   (b) What are the disadvantages of having many children?
3. What is your opinion of the use of 'prevention'?
   (If the interviewee does not mention the following spontaneously, then ask:
   (a) Are there any benefits?
   (b) Are there any dangers?)
4. What methods of 'prevention' do you know?
5. Have you ever received lessons on 'prevention'?
6. Suppose you wished to use 'prevention', what steps would you take?
   (If the interviewee does not mention consent by another, ask: Would you need anyone's permission?)
7. What would be the attitude of the following persons towards your using 'prevention'
   (a) husband
   (b) mother-in-law?
8. Have you yourself ever used 'prevention' in the past?
9. What is the most important thing you would like to provide your children?
10. Where does the family get MOST of its food: Self-grown/Store-bought?

Forty-seven (or 67,1 %) of the ANC attendees (ANCs) were 20-29 years old, and 59 (84,3 %) Para 4 or less. The highest educational standard attained by the majority (56, or 80 %) was standard 6 or less; 10 (14,3 %) left school in standards 7-9, and 4 (5,7 %) after standard ten.

Results

The majority of the interviewees (74,3 % ANCs, 87,9 % nurses – Table 3) regarded 4 or less children as ideal for their families. On being asked whether there were any advantages in having "many children", 43 % of the ANCs answered negatively; and those who discerned some virtue in large families most frequently cited support and companionship in old age (Table 4).

Table 3

How many children would you like to have, all told?

	ANC Mothers		Nurses	
Response	No.	%	No.	%
2	6	8,6	9	27,3
3	9	12,9	2	6,1
4	37	52,8	14	42,4
TOTAL: 4 or less	52	74,3	25	75,8
5 or more	18	25,7	8	24,2

Table 4

What are the advantages of having many children?

	ANC Mothers		Nurses	
	No.	%	No.	%
No advantages	21	41,4	11	33,3
Some advantages	41	58,6	22	66,7
***namely:				
Security in old age	41	58,6	22	66,7
Companionship in old age	39	55,7	22	66,7
Social status	7	10,0	17	51,5
Household help	2	2,9	0	0
Other (God's gift, family name, lobola)	5	7,1	5	15,1

(***Indicate possible multiple responses per respondent; Such responses therefore do not add up to sample size)

On being asked about the disadvantages, nearly all of the respondents (including some of those who disapproved of birth control) cited one or more, the most frequently named being the inability to adequately educate and support the child (Table 5). Only the student-nurses also saw an adverse impact of high parity on maternal health.

On being asked what they most wanted to provide for their children, 87 % of the ANCs and 100 % of the nurses listed education first.

Contraception received the approval of more than 90 % of the respondents (Table 6). Spacing (as opposed to limiting) was seen as the main advantage of contraception. The disapprovers most frequently cited religion or the fear of side-effects. With but a few exceptions, nearly all the ANCs thought of "prevention" solely in terms of artificial contraception (Table 7). On being asked what methods of contraception were known to them, the majority of the ANCs listed only "amaphilisi" (birth control pills) and "umjovo" (an injection of medroxy-progesterone acetate); a third of them also mentioned the intrauterine contraceptive device. This was in contrast to the more comprehensive enumeration by the nurses.

Table 5

What are the disadvantages of having many children?

	ANC Mothers		Nurses	
Responses	No.	%	No.	%
No disadvantages	1	1,4	2	6,1
Some disadvantages	69	98,5	31	93,9
***namely:				
Expensive to educate	67	95,7	31	93,9
Expensive to feed and clothe	67	95,7	27	81,8
Maternal well-being adversely affected	0	0	11	33,3
Inadequate housing	0	0	31	93,9
'Unhealthy' children	17	24,2	0	0
Juvenile delinquency	3	4,3	0	0

Table 6

What is your opinion of prevention

	ANC Mothers		Nurses	
Responses	No.	%	No.	%
Disapprove	2	5,7	2	6,1
Approve	64	91,4	31	93,9
***benefits of contraception:				
Spacing of children	59	82,9	3	90,9
Prevention of unwanted premarital pregnancies	14	20,0	21	63,6
Promote maternal health	0	0	30	90,9
Limit family size	11	15,7	30	9,1
***risks of contraception:				
Know of none	54	77,1	6	18,2
Know of some	16	22,9	27	81,8

***namely:
(ANC mothers) – obesity, 'ill health', sterility, method failure abnormal bleeding problems.
(Nurses) – obesity, menstrual disorders, sterility, method failure, infection, headaches, embolism

Most of the ANCs (77 %) could not think of any risks of contraceptive use (Table 6). Among the nurses, however, a larger proportion (89 %) was aware of a wider spectrum of risks. All of the nurses had previously received instruction on the subject of family planning, whereas only 43 % of the ANCs had been exposed to formal teaching (Table 8); many of the uninstructed women volunteered that they had gained their knowledge from talking with other women.

Table 7

What methods of 'prevention' do you know?

	ANC Mothers		Nurses	
Responses	No.	%	No.	%
Oral contraceptives	70	100	33	100
Injection contraceptives	70	100	33	100
Intra-uterine device	23	32,9	33	100
Barrier methods	0	0	33	100
Coitus interruptus	0	0	33	100
Rhythm method	0	0	33	100
Spermicides	0	0	33	100
Tubal ligation	5	7,1	33	100
Vasectomy	0	0	11	33,3

Only 17 % of the ANCs had previously used contraceptives, compared to 69,7 % among the nurses.

Asked whether they would require anyone's permission to use contraception, 91,4 % of the ANCs answered affirmatively (Table 9), naming some significant person (usually the husband) in whom vested the power of consent. Nurse responses, on the other hand, tended to be evasive and hypothetical and were therefore not used in this portion of the analysis. Whereas 38,5 % of the ANCs anticipated no problems in obtaining such consent in the future, 12,8 % (which included most of the grand multips in the sample) perceived themselves as barred from using contraception by lack of consent. Some women volunteered that their husbands were opposed to birth control on the basis that it might encourage adultery, or interfere with female libido.

Forty percent (40 %) of the ANCs interviewed, while expecting that their husbands would deny them permission, volunteered that they would nevertheless use birth control "secretly" when the need arose (and indeed we believe that many of the women currently using our family planning resources do so surreptitiously).

Table 8

Have you previously received lessons on 'prevention'?

	ANC Mothers		Nurses	
	No.	%	No.	%
Yes	30	42,9	33	100
No	40	57,1	0	0

Table 9

Would you require anyone's consent to use 'prevention'?

	ANC Mothers		Nurses
Responses	No.	%	
No	6	8,6	(Nurse responses unusable - see text)
Yes	64	91,4	
Would responsible person consent?			
Yes/probably	27	38,5	
No	37	52,9	
• Respondent would feel bound by prohibition	9	12,8	
• Respondent would use 'prevention' secretly despite prohibition	28	40,0	

Discussion

The subject of contraception has long been associated with controversy. It was Clarence Darrow, the legendary American jurist who, on being pressed for his opinion on the subject, finally retorted: 'My dear lady, whenever I hear people discussing birth control, I always remember that I was fifth!'

Contraceptive protagonists fall into two groups. First, there are the 'limiters' who see family planning as a means to limit global population growth. This view regards unbridled human reproduction as portending future disaster for the country and the world. The overall fertility rate in the Transkei is stated to be 190 births per 1 000 women in the 15-44 year old range, and the natural population growth rate to be 2,7 %[3]. The latter figure means that the Transkei population will double in 20 years. These figures (which probably hold good for other rural communities on our subcontinent) are astronomical by western standards. But they do not in themselves point to family planning as the panacaea for all

population-related problems. Indeed, the whole concept of 'overpopulation' has been eloquently challenged[4]. And there are social, political, and religious considerations which render this global approach controversial.

Then there are the 'spacers' who equate family planning with sensible chronological child spacing. There is consensus that rational spacing of planned pregnancies promotes the health and well-being of

Children were not regarded as an economic asset.

mother, child and the family as a whole[5]. In this study this perception was also shared by the rural women. Spacing ought therefore to be the *raison d'etre* of rural family planning education programmes. Limiting family size then becomes an individual choice geared to the needs of the individual family, rather than to those of society or the world-at-large. Prevention of unwanted teenage pregnancies and associated problems[6] should be another legitimate goal.

It is often said that rural children represent *current* economic value to their families; indeed, a study by an economist in Indonesia[5] has shown that by his 15th birthday a boy, through his labour at home, has repaid the investment his family made in him. it is therefore striking, and perhaps a reflection of the changing social and economic patterns of rural life in this area, that only 2,9 % of the village women saw children as valuable for their labour (Table 4). The decrease in the number of families owning livestock, the diminution of cultivatable land per family, the increasing encroachment of a cash economy (41 % of the ANCs depended on store-bought food for their subsistence) and the fact that most rural children now spend most of their time in school (which costs money), have all perhaps contributed to the 'decline' of the rural child as an economic asset.

Some wanted larger families for companionship and support in old age.

High childhood mortality rates (190/1 000 live births in the Transkei[7], compared with 18/1 000 among whites) have often been said to account in part for the high parity among rural blacks. However, the need to 'hedge one's bets' was not listed by the interviewees among the advantages of a large family.

Our findings of a high birth control approval rate, the relatively small 'ideal family' size envisaged by the interviewees, and the perception of the rural child as a competitor for family resources rather than a current economic asset, all indicate a potentially favourable disposition toward family planning among the predominantly young women interviewed.

The survey pinpointed some of the major obstacles to optimal use of contraception which are not being adequately addressed by current programmes. The first concerns the importance of rural family relationships *inter se*. Very few of the women interviewed regarded themselves as having the freedom of choice to use contraceptives. In most cases, some other significant person (usually the husband) was acknowledged as having that right. It seems, therefore, that family planning education directed solely at the woman is inadequate and ill-conceived, and is destined to achieve marginal results. It places the woman who wishes to use birth control in an invidious position and is not conducive to family unity. Programmes must thus be designed and opportunities sought to reach the men as well, for example by the institution of health education programmes at factories and mines.

Few rural women were free to use contraceptives.

The majority of women were very receptive to family planning.

A second obstacle is that of inadequate knowledge. The majority of the women had never received accurate information from a professional despite the intensive community health education outreach by our hospital. There is a need for well-designed and coordinated community-based family planning educational programmes, the content of which must emphasise the *economic benefits* of family planning for the family. A Bangladesh study[8] compared the relative effectiveness of family planning campaign themes A, B and C where: A emphasised family economics, B stressed the children's (sons') education and future, and C the health and beauty of the mother. Themes A and B drew the highest response, while theme C had minimal appeal even among the women themselves. As already indicated, family economics and education of the children were areas of greatest concern in our survey.

Family planning educational campaigns may take many forms. The Bangladesh study demonstrated the effectiveness of advertising in newspapers. But posters, radio and television announcements, and free booklets (supplied on specific request in response to adverts) can also be used to advantage.

Family planning programmes should reach the men as well.

Such an 'awareness campaign' will, however, require significant investment in time and money if family planning education is to become a serious endeavour.

References

1. Basu AM. Ignorance of family planning in India: an important constraint on use. Studies in Family Planning 1984; 15:136-142
2. Anderson JE and Cleland JG. The World Fertility Survey and Contraceptive Prevalence Surveys: a comparison of substantive results. Studies in Family Planning 1984; 15:1-13
3. Irwig LM and Ingle RF. Unpublished data generated during the survey cited in 7 below.
4. Simon JL. The ultimate resource. Oxford: Martin Robertson 1981.
5. Morley D. The child's name is today. Contact (Geneva) 1985; Number 86:1-11
6. De Villiers VP. Tienderjarige swangerskappe in die Paarl-hospitaal. S Afr Med J 1985; 67:301-2
7. Irwig LM and Ingle RF. Childhood mortality rates, infant feeding and use of health services in the Transkei. S Afr Med J 1984; 66:608-613
8. Harvey PD. Advertising family planning in the press: direct response results from Bangladesh. Studies in Family Planning 1984; 15:40-2