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ORIGINAL ARTICLE

A STUDY TO ASSESS THE PATTERN OF FAMILY PLANNING ACCEPTANCE WITH RESPECT TO MTP ADOPTION IN AN URBAN MATERNITY HOME

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ABSTRACT: BACKGROUND: Medical Termination of Pregnancy was legalized in India in 1971 with an intention to reduce maternal morbidity & mortality and to reduce the social stigma attached with it. However the clause of performing MTP in the event of "Failure of Contraception" provides a scope to almost everyone for getting an MTP done & its consequent misuse. **OBJECTIVES:** To study the following attributes in the acceptors of family Planning with respect to MTP: Age of female, Monthly Income, Education status, Number of issues, & Age of last child. **METHODOLOGY:** Record Based Study which was conducted in the maternity home attached to the urban health center of the college. The records of 683 women who attended this Maternity Home for adoption of Family Planning in the form of either Copper T or Tubal Ligation, in the years 2010 & 2011 were analysed. **RESULTS:** out of 683 Family Planning acceptors, 272 (40%) had accepted it after getting MTP. A majority of women who underwent MTP were in the age group of 25-34. Monthly Income, Age of last child & number of live issues were factors associated with MTP acceptance while education of the couple wasn't associated. Conclusions: MTP is being used as a method of contraception which represents the unmet need of family planning that needs to be brought down.
KEYWORDS: MTP; Unmet need; family planning.

INTRODUCTION: India, in 1952, became the first country of the world to adopt an official family planning programme. The Current use of overall Family Planning methods in India stands at 56.3% with an Unmet need of 12.8%.[1] Unintended pregnancies occur as a result of this unmet need, and women resort to Medical termination of Pregnancy to end them. Conditions that can lead to a pregnancy being unwanted include and hence terminations are: Having enough children, Unplanned pregnancy, Pregnancy due to contraceptive failure, Previous child too young, others [Unmarried, Rape, medical illness, etc.].[2] Studies have shown that though awareness of contraception is generally high, lack of availability of spacing methods, misinformation or lack of practice of the different contraceptive options leads to abortion being used as an alternative to contraception.[2, 3] Studies have also found that abortion incidence is inversely associated with the level of contraceptive use, and there is a positive correlation between unmet need for contraception and abortion levels.[4]

Current statistics on abortion state that globally 41.6 million abortions took place in 2003, which has risen further in 2008 to 43.8 million. 28 abortions occurred for every 1000 women aged 15-44 years in 2008.The estimated worldwide proportion of pregnancies that end in abortion was 21% in 2008.[5] Abortion as invasive procedures has its own set of complications even in the most skilled hands. These risks include: Hemorrhage; perforation; septicemia; pain during and after the procedure; infertility.

Unsafe Abortion has been defined by WHOM as: "Procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills or in an environment that does not conform

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to minimum medical standards or both." Worldwide, 49% of abortions were unsafe in 2008, up from 44% in 1995. In India 6.5 million abortions occurred in 2008 of which 66% have been deemed unsafe. According to statistics, 13% of all maternal deaths in the south and central Asia region are due to unsafe abortions.[5] Abortion data suffers from under reporting even in our country where the law is so liberal. Monitoring abortion trends is crucial to assess: improvement of maternal health as unsafe abortions lead to a high maternal morbidity, & the progress toward the UN Millennium Development Goal 5 (MDG 5), to reduce maternal mortality and achieve universal access to reproductive health.

Medical Termination of Pregnancy was legalized in India in 1971 with an intention to reduce maternal morbidity & mortality and to reduce the social stigma attached with it.[6] However the clause of performing MTP in the event of "Failure of Contraception" provides a scope to almost everyone for getting an MTP done. Over time MTP has increasingly become a method of contraception with the advent of newer & safer techniques being available & the concession provided by the law. MTP being an invasive procedure has its own risks and getting it done by quacks in unhygienic conditions is even more dangerous. Hence focus should be on prevention in the form of proper adoption of a contraceptive rather than going for an MTP for Failure of Contraception when none was adopted in the first place. We have tried to study the attributes of those couples who had adopted MTP as compared to those who were more vigilant and embraced Family Planning by choice.

The Objectives of the study were to determine the proportion of couples who accepted Family Planning [IUD/TL] with or without MTP & to compare their profile with respect to the following attributes: age of female; monthly income of the family; education status of the couple; no. of issues; & age of last child.

METHODOLOGY: This is a Record Based Study which was conducted in the maternity home attached to the urban health center of the college. The records of 683 women who attended this Maternity Home for adoption of Family Planning in the form of either Copper T or Tubal Ligation, in the years 2010 & 2011 were analysed.

The beneficiaries were classified into 2 groups:

- First group who accepted Family Planning after getting MTP; &
- Second group who accepted Family Planning without needing MTP.

The data was collected and analysed in February-March 2012. Analysis was done by SPSS version 16. Tests applied were simple proportion and Chi Square.

RESULTS [Tables in the End]: Out of 683 women who adopted either IUD or TL, 272 (40%) had accepted it after getting MTP. In the group who got MTP done 51% preferred Copper T over TL whereas in the second group TL was preferred by 51%. 71% of women who underwent MTP were in the age group of 25-34 as compared to 65% in second group. The difference was significant [p value=0.045].

In the first group around 50% had monthly income in the bracket 3000-7000, whereas in the second group the majority (40%) had monthly income >7000 Rs. A significant difference was found between the 2 groups [p value=0.0021]. In this study there was no significant difference between education status of both the partners and the adoption of MTP. 90% women who had got an MTP done had it till two live issues with 58% terminating the unwanted pregnancy after having second

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child. In comparison in self-adopters of Family Planning 28% adopted FP after 1 child, 52% after 2 children and 18% after 3 children. (p value= 0.0096).

A staggering difference was found between the age of last child and the procedure adopted. [p value= <0.0000001]. A large majority (80%) couples underwent MTP and adopted FP when their last issue was between 6 months to 5 years of age. Whereas in the couples who adopted FP preemptively the distribution was spread among all age groups.

DISCUSSION: This is a record based study conducted in a maternity home attached to the Urban Health Centre of our Medical College. During the years of 2010 & 2011, 683 women had adopted family planning in the form of either IUCD or Tubal Ligation. These adopters were of two types: One who underwent an MTP and then adopted a FP method; & second who adopted FP preemptively. In the present study 40% of women who had to undergo MTP before adopting a Family Planning method comprise the missed opportunity of family planning advice and services. We found 25-34 as the predominant age group for adoption of MTP. Previous studies also support this fact. Study by Dhillon et al shows 60% of women in this age group with 53% having parity of 2.[2] Another study by Sehgal et al shows 60% women in 25-29 age group with parity 3 in 58%.[7] Studies by Pazol K (2014),[8] Ibetombi T D (2007),[9] & Khokhar A (2000)[10] support this finding. This fact suggests that the focus of family planning has to stress on the women in age group of 25-34 because during this age group family size is determined by the couple and hence an unwanted pregnancy may lead to its termination safely or unsafely, creating unnecessary morbidity where it is not warranted.

As shown in Table 3 a significant difference in the monthly incomes for the families was seen the two groups with those who underwent MTP being in a lower income bracket as compared to the second group. A higher monthly group may have translated into better awareness and utilization of Contraceptive methods. Education status of the couple didn't seem to make a difference on adoption or non-adoption of MTP as per Table 4 & 5. Increased education did not lead to an increased practice in family planning usage, whereas an enhanced education status should have resulted in better planning and execution of Contraception. This could be attributed to the fact that Sex education is still to be incorporated in the mainstream education for raising awareness and practice regarding family.

The number of live issues seems to make an impact on the couple's decision to keep or terminate a pregnancy as shown in table 6. 90% of MTP adopters had up to 2 live issues shows that the pregnancy was unwanted and the adoption of contraception was deficient. On one hand it is encouraging to note that they wanted to follow the 2 child norm, on the other hand it is equally disappointing to observe that adequate measures of Family Planning if adopted timely could have avoided the unwanted pregnancy & consequent MTP altogether. However, Khokhar A (2000) found that induced abortion were more after the birth of 3rd child.[10]

80% of MTP adopters had chosen the option when their last issue was in the age group of 6 months - 5 years. In comparison the adopters of Family Planning had a more uniform distribution across all age groups of their last issue with majority (47%) in 6 months- 5 years group. This fact suggests that couples wanted to space the pregnancy but failed to properly adopt a method of Family Planning. And hence couples should be approached for family planning advice during the Lactational amenorrhea period for counseling regarding FP methods. The crux of the advice has to be on proper methodology of spacing and the limitation of family size as per the family needs and aspirations.

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CONCLUSIONS: Even after 62 years since the advent of Family Welfare Programme we can see that there is a huge gap between the requirement and the supply of contraceptive services to the masses. Out of 683 adopters of Family Planning 272 (40%) had got a MTP done. This figure represents the unmet need of family planning consequent to lack of knowledge or practice of contraception. This also exemplifies the failure on the part of Health workers to motivate the couples to adopt contraception as a life choice in time.

The factors that favoured positively in a couple going for MTP as per the study are: Age of female >25 years; lower income of the family; 1-2 live issues; & age of last issue between 6 months-5 years. Education of the couple didn't seem to make an impact on their choice of contraception. Whereas studies have shown that education improves the choices regarding family planning.

MTP is being used as a method of contraception. On one hand this can be attributed to increasing awareness and safety of the procedure, however it also exemplifies the fact that the actual methods of contraception are not being properly adopted by the couples. The reason behind this unmet need should be explored in detail.

RECOMMENDATIONS: As per this study we can cite the following recommendations: Women in the age group of 25-34 have to be made more empowered regarding the usage and availability of Contraceptive methods. Also the educational system has to be made a part of the process. Sex education should be included in the curriculum as the children will feel more comfortable if their elders & teachers are involved in the process. Following delivery and during the first 3 months the couple should be approached vigorously for FP counseling and an individualized approach to be followed.

LIMITATION: This study has been conducted in only one maternity home and only married couples' data could be included. Hence the data cannot be extrapolated.

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Procedure	IUCD	TL	Total
FP with MTP	140	132	272 (40%)
FP without MTP	200	211	411 (60%)
Total	**340**	**343**	**683**

TABLE 1: Procedure Adopted: Method wise

Chi square=0.5165 p value= 0.47.

Procedure	15-24	25-34	35-44	Total
FP with MTP	50(18.4%)	194(71.3%)	28(10.3%)	272
FP without MTP	109(26.5%)	267(65%)	35(8.5%)	411
Total	**159**	**461**	**63**	**683**

TABLE 2: Procedure Adopted & Age of Female

Chi square=6.199 p value= 0.045.

Procedure	< 3000 Rs	3000-7000 Rs	>7000 Rs	Total
FP with MTP	53	135	84	272
FP without MTP	95	149	167	411
Total	**148**	**284**	**251**	**683**

TABLE 3:Procedure Adopted & Family Monthly Income

chi square=12.2753 p value= 0.00216.

Procedure	Illiterate	Primary Education	High School	Graduation & above	Total
FP with MTP	25	39	149	59	272
FP without MTP	32	77	208	94	411
Total	**57**	**116**	**357**	**153**	**683**

TABLE 4: Procedure Adopted & Education of Female

chi square=2.896 p value=0.4078.

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Procedure	Illiterate	Primary Education	High School	Graduation & above	Total
FP with MTP	20	51	130	71	272
FP without MTP	25	85	200	101	411
Total	**45**	**136**	**330**	**172**	**683**

TABLE 5: Procedure Adopted & Education of male

Chi square=0.8848 p value=0.829.

Procedure	1	2	3	≥4	Total
FP with MTP	86	160	21	5	272
FP without MTP	117	216	66	12	411
Total	**203**	**376**	**87**	**17**	**683**

TABLE 6: Procedure Adopted & Number of live issues

Chi square=11.42 p value= 0.0096.

Procedure	<1 Month	1-6 month	6 month-5 years	>5 year	Total
FP with MTP	0	10	219	43	272
FP without MTP	79	72	193	67	411
Total	**79**	**82**	**412**	**110**	**683**

TABLE 7: Procedure Adopted & Age of Last Child

Chi square=109 p value<0.00001.

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