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PREVALENCE OF FAMILY PLANNING METHODS AMONG MARRIED WOMEN AT THQ HOSPITAL SHABQADAR CHARSADDA KPK PAKISTAN

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ABSTRACT

Background: *Developing countries are facing rapid growth of papulation due to different reasons such as high fertility rate. Different methods of family planning are using one of them is Today method of family planning in which cervix secretion is noticing for two consecutive days, if there is cervical secretion then unprotected sex may be avoided. Other methods of family planning include oral contraceptives, injectable, IUCD, male condom.*

Objectives:

Purpose *–To assess the prevalence of family planning methods in married women at THQ Hospital shabqadr*

Methodology:

Study Design- *Descriptive cross sectional survey.*

Sampling Techniques- *convenient sampling technique.*

Sample Size- *Total 273 participants were selected for the study and sample size was calculated through OpenEpi on the basis of 23% proportion of family planning in KPK with 95 % of confidence interval and 5% margin of error,*

Results: *Participants were inform from different sources, 35.1% got information about family planning from government hospital, while 5.9% source was their friend health worker also use as source of information for 56.4% and 2.6% subjects were informed by their relatives, the results showing in the figure. Different methods were use 23.4% IUCD, Injectables,13.9%, implant 10.3%, pills, 19% Condom.*

Conclusion: *Family planning is very important in this over populated world especially in fast growing populated country Pakistan. Different sources working on awareness about family planning, lady health workers are more involve in the awareness which is highly appreciated. Oral contraceptive pills are abundantly using method in this study. More awareness is required about side effect and contraindication of this method.*

Keywords: *Prevalence, Family planning, THQ Shabqadar*

INTRODUCTION

Developing countries are facing rapid growth of papulation due to different reasons such as high fertility rate.(1) overpopulation lies on heart of the Pakistan social, economic and political problems. After

independence and before Bangladesh separation Pakistan was the 13th papules country in the world with papulation of 32.5 million but in 1996 it was the 7th in the world with a papulation of 162millions. It is estimated that this papulation would be 5th in the world. (2) Papulation growth can effect different sections of life one of them is economic effect because papulation increases geometrically double and then so on but food production increases slowly so it leads to scarcity and shortage of food as well as different assets necessary for life. (3)

Different methods of family planning are using one of them is Today method of family planning in which cervix secretion is noticing for two consecutive days, if there is cervical secretion then unprotected sex may be avoided(4)Other methods of family planning includes oral contraceptives, injectable, IUCD, male condom.(5, 6)

Some participants viewed the risks of the side effects of modern contraceptive methods as outweighing their benefits. They also perceived that the quality of modern contraceptive medicine available in the country was unreliable, which made people suspicious and fearful of using it. Some participants, particularly women, noted that people who want good quality modern contraceptive medicine purchased it outside the country.(7)

Family planning experts deliberately avoid pregnancy while reporting contraceptive risk events; so, optimizing the role of contraception with access and education does not eliminate the need for abortion. Contraceptive uptake that satisfies the needs of its user should be recognized, as should advancements in the diversity and technology of contraceptive methods. Talking about how contraception can reduce or eliminate the need for abortions, however, maintains the stigma associated with the procedure and fails to adequately reflect people's actual experiences, especially those who have great social and educational advantage, such as family planning professionals. Furthermore, persons with specialist understanding of contraception employ tailored algebra to determine method goodness of fit, not just for efficacy concerns, much like all other users of contraceptives. Practical and significant considerations, such as side effects and convenience of use, influence contraceptive choices and method avoidance, which significantly narrows the range of options available to modern contraceptive users. Even for those with a great deal of personal interest and professional training in contraception, contraception has not and will not eliminate the need for abortion. Given the substantial losses in abortion protection, the expansion of access to and availability of contraception should be welcomed as important steps toward promoting reproductive liberty.(8)

Family planning programs aim to give customers a wide range of contraceptive options while adhering to the notion of informed choice. However, a variety of obstacles, such as supply and demand issues, restrict a person's access and real choice. Due to this circumstance, a significant proportion of women—214 million women in developing nations, according to estimates—do not receive the contemporary contraception they require.

Equal choice for all is a fundamental right (Box 2) and is required to satisfy the various needs of customers. It has been noted that provider prejudice significantly impedes people's ability to exercise their freedom to choose and violates the principle of nondiscrimination, especially for those with the greatest unmet needs, such as the impoverished and adolescents. In order to effectively address provider bias in contraceptive services, it is necessary to describe and comprehend it accurately.

The idea of provider bias gained prominence in a seminal 1992 publication on medical barriers to family planning access, and in the 1990s, situation analysis studies conducted in numerous nations gave the concept greater quantitative substance. Provider bias, while widely acknowledged as a significant impediment to choice over the years, has not always been well defined. The New Oxford American Dictionary lists five forms of bias as follows: bias that is either in favor of or against something, someone, or a group in comparison to another, frequently in a way that is viewed.

In addition to capturing the idea of fairness and a human rights perspective, this definition emphasizes prejudice as an attitude. One of the six categories of medical barriers identified by Shelton et al. was provider bias. The other categories were eligibility requirements, process obstacles, who delivers contraception, provider bias, eligibility restrictions, and regulation. They clarified. These barriers to [family planning] are thought to be behaviors that, while perhaps having a medical justification in some cases, lack scientific backing.

Supplier bias has a significant impact on the techniques that customers employ. Provider prejudice is frequently motivated by erroneous medical reasoning. This kind of prejudice affects how practitioners present and suggest various approaches. While there is overlap and interaction between these barriers, our goal in this review is to identify and examine provider bias separately because tackling each calls for particular kinds of treatments. Bertrand et al. provided one of the earliest definitions of provider bias in the literature in their 1995, This barrier encompasses the custom of endorsing certain approaches and forbidding others when there is no discernible benefit. Medical justification, in addition to neglecting to determine and to observe the client's wishes.(9)

Due to its shown ability to lower mother and child mortality, family planning is widely recognized as a crucial intervention for accomplishing Millennium Development Goals (MDGs) four (4) and five (5) . Safe abortions and unintended pregnancies can be avoided with family planning. Certain family planning practices, such as using condoms, can shield people against HIV/AIDS and other sexually transmitted infections (STIs). It has also been discovered that family planning supports women's economic and educational empowerment as well as gender equality. In Sub-Saharan Africa, the use of family planning services is still low despite their many advantages.

This has led to high incidence of unintended pregnancies, unplanned births, unsafe abortions, and maternal deaths throughout Sub-Saharan Africa, including Ghana. Numerous causes are mostly to blame for the low adoption rate of family planning. The usage of family planning services has been found to be significantly influenced by people's awareness of the services' availability.

Furthermore, some women are aware that family planning services are available, but they lack adequate knowledge about the different types of family planning procedures and how they operate. A portion of the women who sought out family planning services did not receive sufficient counseling regarding the potential adverse effects of some family planning techniques. For instance, in Uganda, several women discontinued using contraceptives due to what they believed to be adverse reactions. Despite the fact that the majority of people are aware of the advantages of family planning services, many expressed dissatisfactions over the difficulty of obtaining them because the health facilities where they were offered were located distant from their homes.

Furthermore, it has been shown that a significant barrier to the use of family planning services in Africa is religious predisposition. Additionally, some people believed that family planning services were solely intended for married couples, while others worry that if they use family planning after they are unable to conceive, they will turn into promiscuous people. Through the execution of various programs, the Ghanaian government and non-governmental groups have made some efforts to increase the country's coverage of family planning services. The country's unmet need for family planning remains significant, despite modest achievements in raising awareness of family planning services. According to the Ghana Demographic and Health Survey (GDHS), many women have unmet family planning is necessary because few people are using family planning services.(9, 10)

Despite the clear need for quick, high-quality care, access to family planning and health services is severely limited in Pakistan. Some recent studies in the fields of family planning and health have examined service accessibility; the results, however, are tentative and mostly quantitative. According to research, women's movement in rural areas is primarily confined to the boundaries of the hamlet. In terms of getting health care, it is a little less constrained. I conducted a small-scale qualitative study in rural Northern Punjab in 1996 to find out why women's mobility is restricted and how this affects their access to family planning and health services. Since 1990, the percentage of married women in Pakistan who use contraception has climbed to 23.9% of all women of reproductive age.

Nonetheless, it is estimated that 37.5% of married women in this age range wish to space or restrict their children and do not use any kind of contraception. Research has led to investigations into the limitations that women experience, and some significant results have been obtained. A survey discovered that the majority of people who visit the 1,286 Family Welfare Centers run by the government are local family planning clients, as they arrive on foot.

According to respondents in rural areas who had never used a contraceptive method, the nearest service facility was three miles away on average, according to the Pakistan Contraceptive Prevalence Survey (1994–1995). Unsurprisingly, subsequent research revealed that a woman is less likely to use a family planning method the longer it takes to get in contact with a source, and that this constituted a significant barrier to X CeSSing Contraception. In response to this issue, the state has created two programs to improve access for women from rural areas. The Ministry of Population is one. Welfare's Family Planning Worker in the Village plan. The female health worker is the other. program, carried out by the Ministry of Health. The foundation of both designs is the idea of doorstep, neighborhood-based programs, and recommendations systems. The government increased the number of doorstep workers in its ninth Five-Year Plan (1998–2003) in response to the effectiveness of these programs across the country in raising referral rates and the utilization of available services; however, the specifics of this macro-development framework have not yet been finalized. In a nationwide research, just 6% of married women reported having had a family planning worker visit them at home in the 12 months before to the interview, and 9% reported having a health worker visit them.(10, 11) this study focused on prevalence of family planning methods in shabqadar which is still unexplored.

Rationale

Rapid growth of the world and specifically of Pakistan is a problem for the next generation, by prevalence of family planning methods we can control the rapid papulation growth which is necessary for limited resources, infrastructure and social services.

Similarly, by studying the prevalence of family planning methods is also necessary for improving the reproductive health outcomes, and also for cases having limited accesses to contraceptive methods and education.

Controlling over papulation also have a great effect on sustainable financial status and decrease poverty.

It also improves health status and maternal and infant mortality rate decreasing, by providing space to pregnancies.

Data on prevalence of family planning methods also give enough stuffs for policy making documents.

Objectives

Purpose –To assess the prevalence of family planning methods in married women at THQ Hospital shabqadr

Target Audience- married women are the target audience

Research Question

What is the prevalence of Family planning methods in married women of shabqadar charsadda kp?

Literature Review

Family planning (FP) has shown to be a successful strategy in reducing poverty and preventing maternal and infant mortality during the last forty years. A 10% decrease in child mortality and a 32% decrease in the chance of maternal mortality have been linked to the employment of FP techniques. Evidence from the international literature on family planning also shows that By adopting modern contraceptive methods, women who want to delay or cease having more children could avoid 20% of obstetric-related deaths and 90% of abortion-related deaths. With FP, women have the freedom to choose their sexual health, parity, and the time between unintended or planned pregnancies. (12)

Pakistan is currently the sixth most populous country in the world, with 220 million inhabitants and an annual growth rate of 2.4%. This is associated with one of the highest fertility rates in the region (3.55) (regional fertility rates range from 2.05 to 2.25), and the lowest Human Development Index (151), when compared to its contemporaries, India (113), Bangladesh (119), Iran (73), and Sri Lanka (66). Signatory to the FP2030 (formerly FP2020), Pakistan has struggled to meet its commitment to increase the country's

contraceptive prevalence rate (CPR) to 60% by 2030 and 50% by 2025. The CPR in Pakistan has stayed at about 35% since 2012, despite significant funding and programming from the government and donors.(13)

India has improved over time in terms of FP-related metrics (e.g., the fertility rate decreased from 4.97% in 1980 to 2.44% in 2015). Notwithstanding this accomplishment, India is still far from meeting several of the SDG's objectives, such as meeting 75% of the overall demand by the use of contemporary FP techniques. Indian women, especially those from lower socioeconomic classes, have a high rate of unmet FP requirements.8 54% of married women and 44% of all women aged 15 to 49 use contraceptives of any kind, while 38% of married women and 48% of all women aged 15 to 49 utilize contemporary methods of contraception. These women had a significant rate of contraceptive discontinuation within a year of use, which can be attributed to a number of causes.(14)

The effect of family planning on fertility in Bangladesh is still up for dispute. Government family planning programs spent a lot of time and money trying to lower fertility, but they were not very successful until the mid-1980s. The minor rise in contraceptive use in Bangladesh did not significantly affect fertility, according to an analysis of data from the Poverty and Fertility Survey, which was carried out in 1977 in four rural parts of the nation. According to this study, the number of children born was strongly correlated with both child mortality and the usage of contraceptives. The fact that the use of contraceptives typically started late in life helps to explain the positive link between the number of children born and the usage of contraceptives.

This suggests that although high child and newborn mortality and secondary sterility (at higher ages) dominated Bangladesh's fertility pattern over the study period, contraceptives may have some effect in reducing fertility at higher parities. Numerous other studies conducted during this time period also supported the idea that using contraception had little to no benefits for families examined patterns in reducing fertility at higher parities. Numerous other studies conducted during this time period also supported the idea that using contraception had little to no benefits for families. examined patterns in contraceptive use between 1969 and 1983 and discovered a consistent rise in conception among all women, regardless of parity, education level, or place of residence. Contraceptive use was more common among women who lived in cities, had higher parity, and had greater levels of education. In Matlab, Bangladesh, compared trends in family size preferences and the use of contraceptives in treatment and comparison areas. They concluded that while modernizing influences, education, and growing diversity contributed to changes in reproductive preferences, family planning and maternal-child health programs were successful in addressing reproductive preferences in the treatment area.(15)

Of the 1.9 billion women in the world who are of reproductive age, 1.1 billion have family planning needs; 840 million of them use contraceptive techniques, while there are 270 million who do not have access to contraception globally.1. In low- and middle-income countries (LMICs), where maternal mortality accounts for 99% of all maternal fatalities, family planning is crucial to lowering maternal mortality.

The importance of family planning for women's health was underlined at the 1994 International Conference on Population and Development. Meeting the unmet need for contraception alone led to a 29% drop in maternal fatalities and a 44% reduction in maternal mortality overall, per a 2012 study on the use of contraception in 172 countries.2. Increasing the number of people using contraception in LMICs, where maternal deaths, unplanned births, and unmet contraceptive demand are still prevalent. Pakistan ranks sixth in the world in terms of total fertility, with 3.6 births per woman.

The Pakistan Demographic and Health Survey 2017–2018 reports that 25% of married women aged 15–49 use modern contraceptives, and 17% of married women do not utilize family planning as needed. Furthermore, there is a significant rate of dropout, particularly with intrauterine devices.

According to a survey, 56.5% of those women, or more, do not use other techniques. Prior to implementing the Lady Health Worker Program, the nation introduced its first family planning program in 1960. Nevertheless, the government is still having trouble getting more people to use contemporary contraceptives, 60 years after it was established. Pakistan pledged to meet the family planning industry's 2020 target of providing universal access to reproductive health care by achieving a 55% prevalence rate of contraception by 2020.

Previous research has identified age, education, religion, traditional ways of life, and the economy as social, cultural, and environmental influences. ideals and views, women's status, socioeconomic status, and Factors such as location, autonomy, and knowledge level that affect family planning techniques.(16)

The improvement of mother and child health is found to be significantly influenced by family planning and mother-child healthcare initiatives. These initiatives also lower the rate of maternal death in poor nations. Even with the substantial benefits that family planning and mother-child healthcare initiatives have for the social and economic advancement of society, there is still a need for family planning that is not being met, particularly in developing nations where 225 million women did not use family planning in 2014.

A number of studies and worldwide publications have noted that married women who do not use family planning strategies well have poorer maternal health outcomes. The 2019 State of World Population Report provides statistical evidence that married couples use both conventional and contemporary birth control methods. Globally, married women between the ages of 15 and 49 have a prevalence rate of 63 for the traditional family planning approach and 61 for the contemporary family method. According to the same survey, in less developed regions, the rate of family planning using the traditional technique is 62, while the rate using the modern way is 57. Similarly, among married women aged 15–49 in Asia and the Pacific, the prevalence of modern family planning methods is 62, while the rate for traditional family planning methods is 67.

In Pakistan, married women aged 15 to 49 have a prevalence rate of 42 for traditional family planning methods, compared to only 33 for contemporary family planning methods (UNFPA, 2019). It is also quite concerning that 46% of Pakistani women do not intend to use family planning techniques in the future, according to the Pakistan Demographic and Health Survey Report (2018). Similarly, according to data from the National Institute of Population Studies (NIPS), only 25% of married women are employed now, down 1% from the previous year. In Pakistan, contemporary contraception methods between 2014 and 2018.In both public and private sources, married people make up 44% of the choices.

women should use contemporary methods of birth control (NIPS and ICF, 2018). As per the results of the Pakistan Demographic and Health Survey (PDHS) of 2018, the prevalence of contraception is 34% overall, of modern methods of contraception is 25%, and of traditional methods among married women aged 15–49 is only 9%.

Due to a lack of exposure to awareness programs in the nation's media, the prevalence rate of all family planning methods is lower (NIPS and ICF, 2018). It is noteworthy to note that in Pakistan, 76% of women and 51% of men do not often see media messages about family planning. Television is the most probable media source to provide family planning messages, yet fewer than one in twenty-three married women aged Girls 15–49 are subjected to advertising on television regarding the use of family planning techniques. Only 2% of married women in Pakistan were exposed to family planning messages on the radio, 3% were exposed to them in newspapers, and 1% were exposed to them on their cell phones (NIPS and ICF, 2018).(17) Pakistan pledged to fulfill its FP obligations under FP2030 [11].

There is a strong desire to increase the share of contemporary contraceptives—especially long-acting reversible contraceptives (LARC) or permanent methods—that satisfy FP demands as part of SGDs . In order to do this, a focused strategy was used to reach the most vulnerable and marginalized women. Offering client-centered counseling and facilitation at facilities is one way to increase the use of contemporary contraceptives. This helps clients choose appropriate contraceptive methods, stick with them, and come back for more help if necessary. In addition to supporting women's reproductive rights and enhancing a client's self-concept, client-centered counseling and facilitation can help foster trust in services.

In Pakistan, where only 19% of women have access to information that can help them make an informed decision, there is, however, limited data on the application of such a strategy to increase the uptake of contemporary contraceptives. Urban slums and other impoverished places have significantly less access to data. In Rehri Goth, one of Karachi's poorest urban slums, the non-governmental organization VITAL Pakistan Trust implemented a client-centered counseling and facilitation method. The counseling method has been incorporated into the current MNCH service delivery package to enhance the use of contemporary contraceptives, with particular goals to boost LARC promotion or advise MWRA on permanent methods

when necessary. In this paper, the following objectives are to be addressed: (i) the adoption rates of all current methods of contraception as well as LARC or permanent methods following the implementation of client-centered counseling and facilitation by FP service providers; and (ii) the identification of maternal and sociodemographic factors and the reasons for the inadequate adoption rates even with counseling.(18)
Pakistan, the nation with the fifth-highest population, is facing a number of difficulties, including a rapidly growing population and a significant unmet need for contraception. The percentage of people using contemporary contraception today is 26%, and this number hasn't changed in the previous five years. The two most commonly utilized techniques are female sterilization and condom use. Low contraceptive use is caused by a variety of supply-side and demand-side issues, such as health concerns, women's perceptions of FP's sociocultural unacceptability, and subpar service quality. The nation has been implementing pro-poor policies, particularly voucher coupons, for the past ten years in an effort to improve access to and use of high-quality maternal and reproductive health services for marginalized communities. These policies have shown promise in improving maternal and reproductive health outcomes, including institutional birth. Despite their effectiveness, voucher programs' long-term viability from a programmatic and user behavior perspective—such as the maintenance of contraceptive use—is viewed as a possible obstacle.(19, 20, 21)

Methodology

Study Design- Descriptive cross sectional survey.

Sampling Techniques- convenient sampling technique.

Sample Size- Total 273 participants were selected for the study and sample size was calculated through OpenEpi on the basis of 23% proportion of family planning in KPK with 95 % of confidence interval and 5% margin of error

Ethical Considerations**:** Before starting the study approval taken from head of the Gynea department of THQ hospital Shabqadar. Informed consent signed from each participant. Kept all the information confidential as per ethics and norms rules of the research.

Inclusion Criteria- Those women with age of 15-44 and sexually active

- Those women who visit the OPD of THQ Shabqadar for any sort of treatment and willing to participate.

Exclusion Criteria-

- Those were not willing to participate voulantarly
- Those with history of mental health problems

Study Setting- THQ Hospital Charsadda Kp Pakistan

Results

Using SPPS version 27 for data entry purposes and same software used for statistical analysis, frequencies and percentages calculated for categorical variables as fallow

Demographic statistics

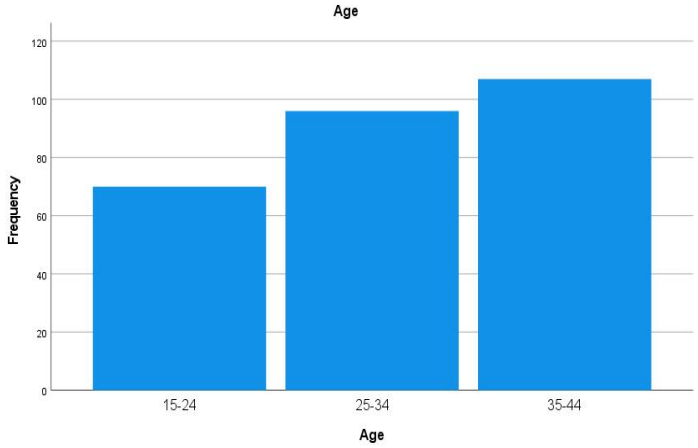
In total 273 sample size age which was recorded as 25.6% ware in the age of 15-24years, 35.2% were in the age of 25-34 and similarly 39.2% were in age of 35-44. As shown in the figure.

Table 1 Age of the participants

Table 1 Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	15-24	70	25.6	25.6	25.6
	25-34	96	35.2	35.2	60.8
	35-44	107	39.2	39.2	100.0
	Total	273	100.0	100.0	

Figure 1 age. demographic .

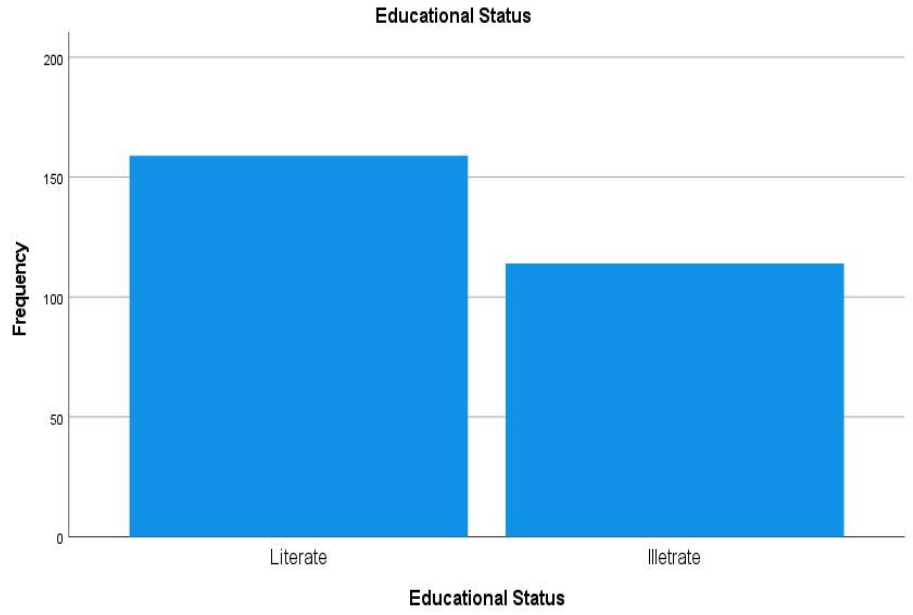


While looking to the educational status of the participants out of 273, 58.2% were literate while illiterate were 41.8% representing in the fallowing figure.

Table 2. educational status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate	159	58.2	58.2	58.2
	Illetrate	114	41.8	41.8	100.0
	Total	273	100.0	100.0	

Figure 2.Educational status

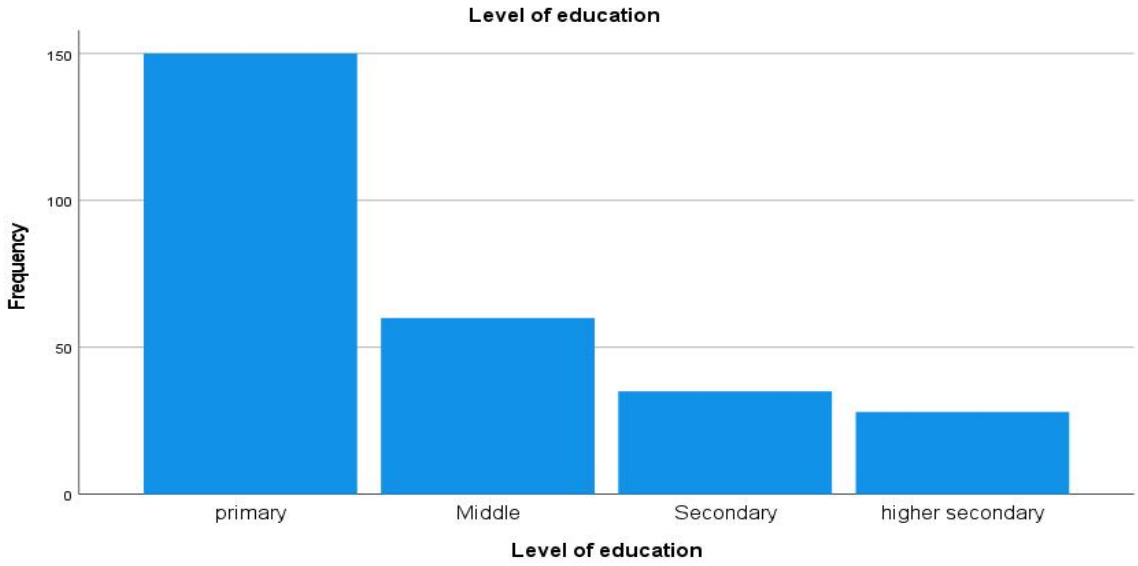


While the demographic data of educational status it is noted that 54.9% were primary qualified, 22% were middle school qualified, the secondary school qualified were 12.8%, higher secondary school qualified were 10.3% as shown in figure.

Table 3Level of education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary	150	54.9	54.9	54.9
	Middle	60	22.0	22.0	76.9
	Secondary	35	12.8	12.8	89.7
	higher secondary	28	10.3	10.3	100.0
	Total	273	100.0	100.0	

Figure 3. Level of Education

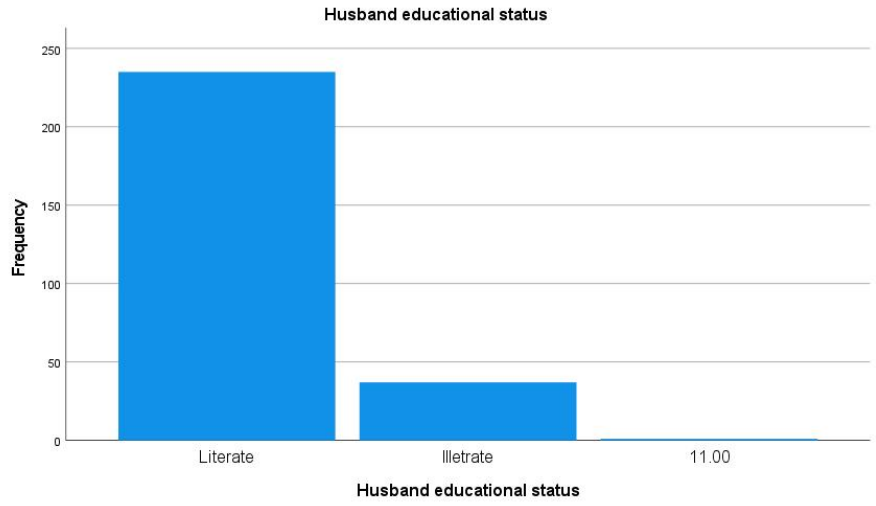


Looking to the husband educational level of the participants, it was recorded that 86.1% were qualified while 13.6% were illiterate, the fallowing figure is showing.

Table 4Husband Educational Level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate	235	86.1	86.1	86.1
	Illetrate	37	13.6	13.6	99.6
	11.00	1	.4	.4	100.0
	Total	273	100.0	100.0	

Figure 4. Husband educational status

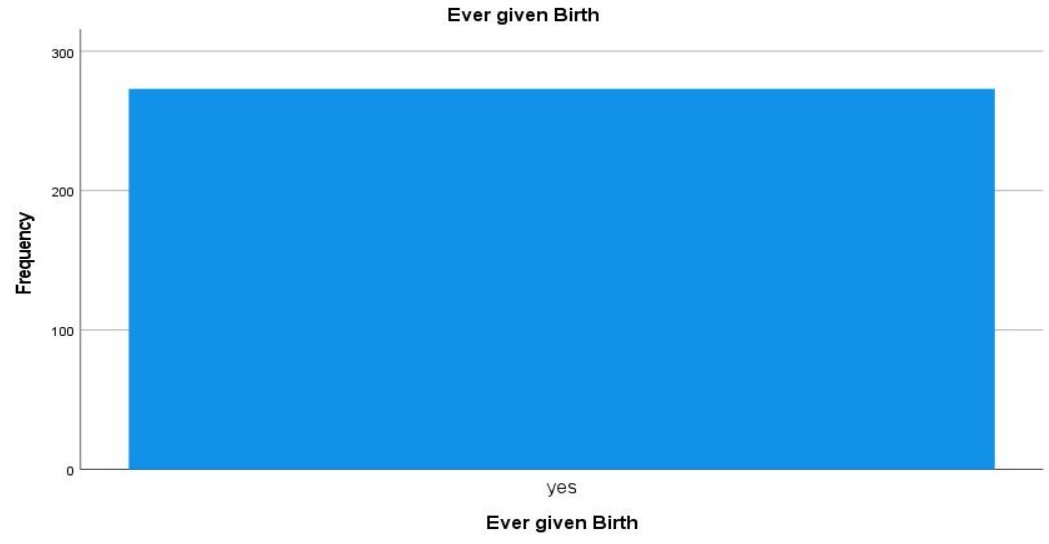


In demographic data it is recorded for the respondents about ever given birth it is recoded that 100% participants given birth as shown in the figure.

Table 5Ever Given Birth

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	273	100.0	100.0	100.0

Figure 5. Ever given birth



Among the respondent number of child recoded as the subject having 1 child are 11.4%, having 2 child are 48.4% and the respondent with bearing children more than 2 are 39.6% , figure is showing.

Table 6No of Child

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	2	.7	.7	.7
	1	31	11.4	11.4	12.1
	2	132	48.4	48.4	60.4
	more than 2	108	39.6	39.6	100.0
	Total	273	100.0	100.0	

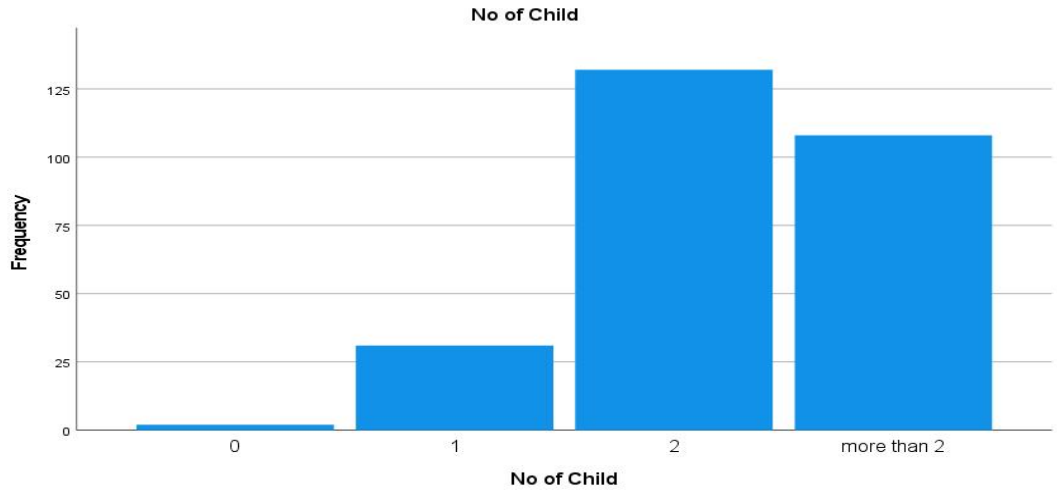


Figure 6. No of child

Type of family among the participants 48.4% living in single type of family and 51.3% are belonging with joint type family, representing in the figure.

Table 7Types Of Family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	132	48.4	48.4	48.4
	Joint	140	51.3	51.3	99.6
	3.00	1	.4	.4	100.0
	Total	273	100.0	100.0	

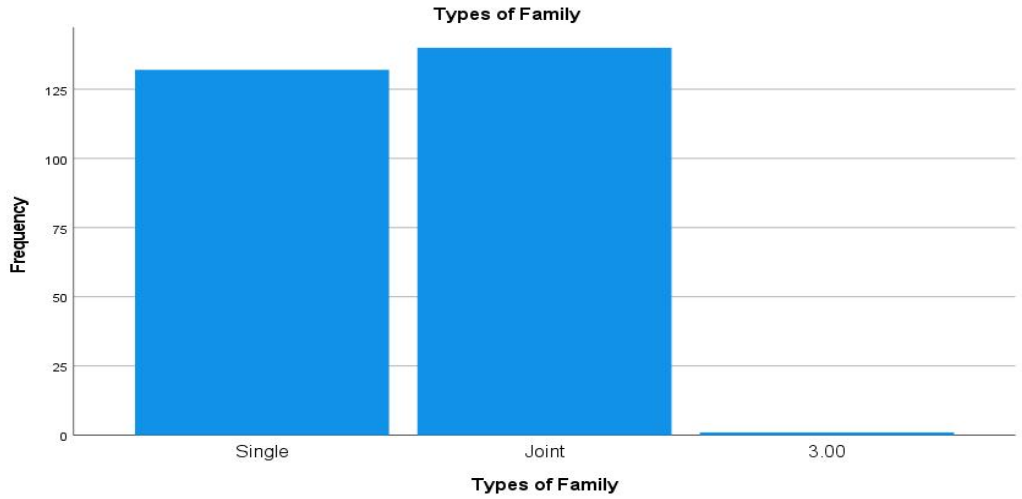


Figure 7. Types of family

Knowledge of Family Planning

Participants were inform from different sources, 35.1% got information about family planning from government hospital, while 5.9% source was their friend health worker also use as source of information for 56.4% and 2.6% subjects were informed by their relatives, the results showing in the figure.

Table 8Source of Information

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Govt hospital	96	35.2	35.2	35.2
	Friend	16	5.9	5.9	41.0
	Health worker	154	56.4	56.4	97.4
	Relatives	7	2.6	2.6	100.0
	Total	273	100.0	100.0	

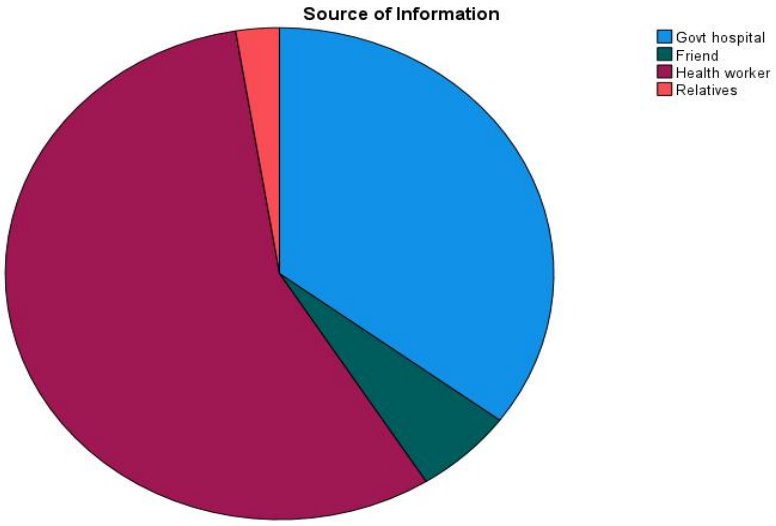


Figure 8. Source of Information

Almost all the participants were aware about the availability of family planning methods 99.6% only one subject was disagreeing with the availability which is 0.4% , as shown in the figure.

Table 9Place of availability family planning method

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	272	99.6	99.6	99.6
	No	1	.4	.4	100.0
	Total	273	100.0	100.0	

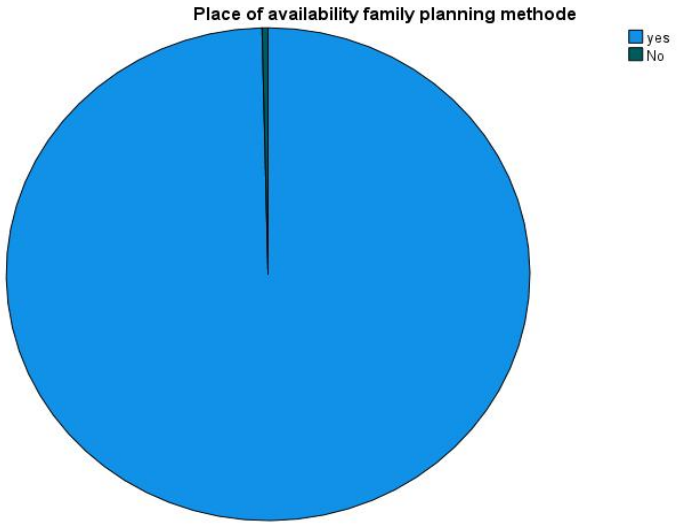


Figure 9. Place of availability family planning method

The knowledge about places where family planning methods are available, the subjects with availability of in hospital are 21.6%, similarly 30.8% in PHC, in the pharmacy 28.6% and in private hospitals availability is 28.6%, representing in the fallowing figure.

Table 10Place of availability family planning methods

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Govt Hospital	59	21.6	21.6	21.6
	PHC	84	30.8	30.8	52.4
	Pharmacy	78	28.6	28.6	81.0
	Private Hospital	52	19.0	19.0	100.0
	Total	273	100.0	100.0	

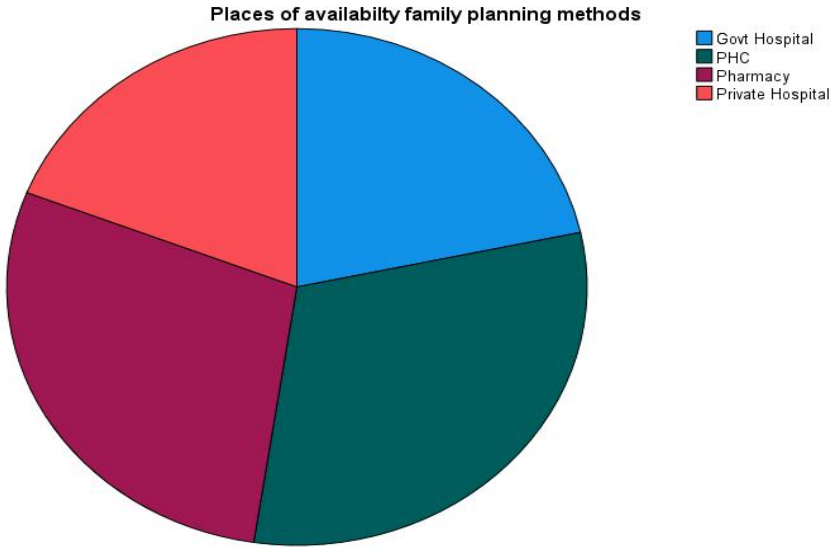


Table 11Practice of family planning methods

100% subjects were yes regarding use of any family planning method, shown in the figure.

Statistics

		Have you used Family planning method	Used Family planning methodes in past	Current use of Family planning Method	Currently used Family planning method
N	Valid	273	273	273	273
	Missing	0	0	0	0

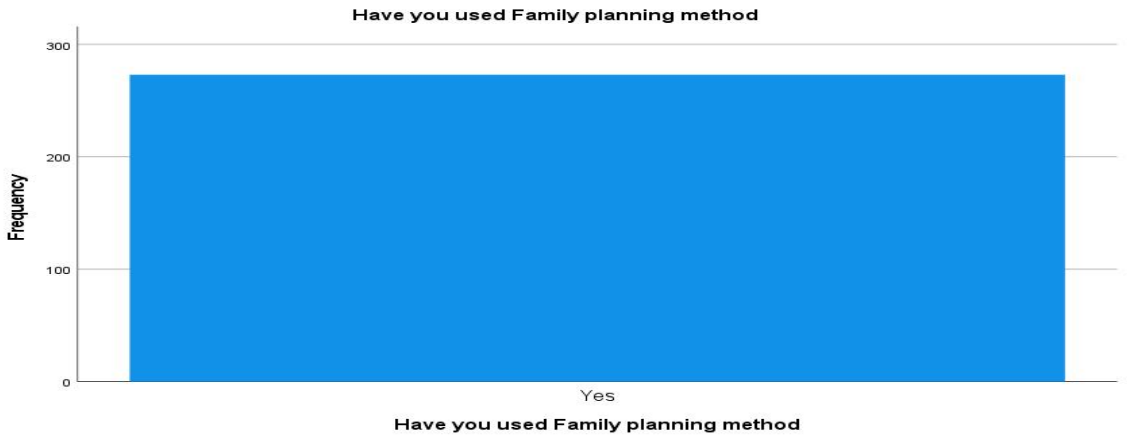


Figure 10. Have you used family planning method

Family planning methods which were used in past by the participants are 23.4% IUCD, injectable method was use 13.9%, implant method was use by the participants for 10.3%, pills were used by the 33.3% participants and condom was in past practice of the 19%, data is presenting in the fallowing figure.

Table 12Used family planning methods in past

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	IUCD	64	23.4	23.4	23.4
	Injectable	38	13.9	13.9	37.4
	Implant	28	10.3	10.3	47.6
	Pills	91	33.3	33.3	81.0
	Condom	52	19.0	19.0	100.0
	Total	273	100.0	100.0	

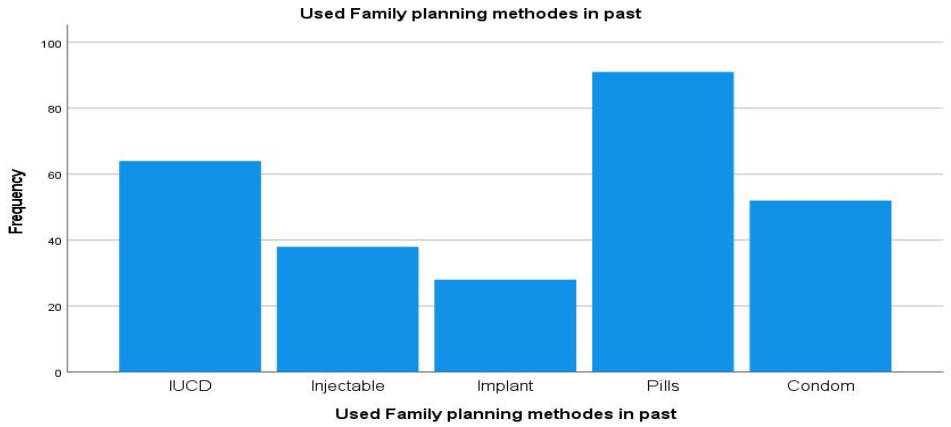


Figure 11. Used of family planning methodes in past

Participants either currently practicing family method or not, almost all the subjects using family planning method 100%, results describe in the fallowing figure.

Table 13Currently use of family planning method

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	273	100.0	100.0	100.0

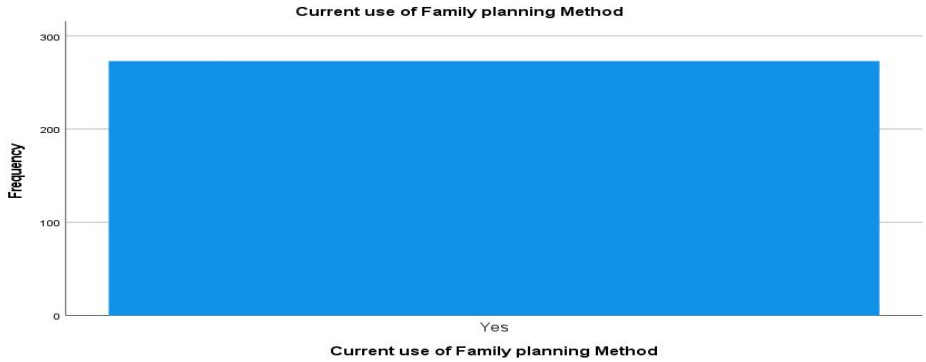


Figure 12. Current use of family planning method

Subjects with currently practicing family planning method are 26.4% IUCD, injectable method used by 13.6%, implant method used by the 14.7% participants, 30.8% subjects are using pills for the family planning. Condom is using by the 14.7% participants, figure representing the result.

Table 14Currently use family planning method

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	IUCD	72	26.4	26.4	26.4
	Injectables	37	13.6	13.6	39.9
	Implant	40	14.7	14.7	54.6
	Pills	84	30.8	30.8	85.3
	Condom	40	14.7	14.7	100.0
	Total	273	100.0	100.0	

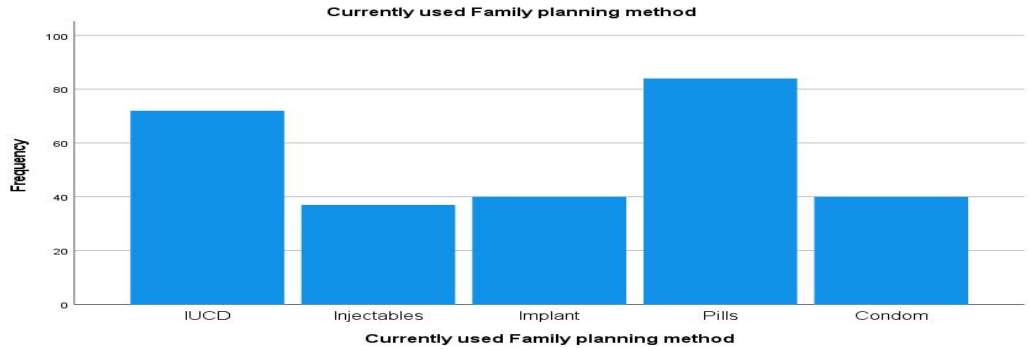


Figure 13. Currently used family planning method

Discussion

A study about different family planning methods performed in the hospital of medical college of Nepal with illiterate subjects of 38% , and 62% illiterate participants are aware about oral pills 78%, condom 71%, IUCD 47%, while in this study, 58.2% were literate and 41.8% were illiterate were aware about 26% IUCD, 30% are pills users, condom users are 14.7%.

Depo Provera was known by 97.0% of respondents to the 1993–1994 Bangladesh Demographic Health Survey, followed by IUCD (90.0%) and condoms (87.0%).13. The Renjhen et al. study found that oral contraceptive pills had the highest awareness (95.8%), followed by condoms (74.2%) and IUCDs (72.0%).11. According to Srivastava et al., IUCD was the most popular short-term technique (61%), followed by oral contraceptives (60%) and condoms (50%).

Just 6.0% of people were currently using a method, and just 3.5% were using a modern method, according to the Nigerian Demographic Health Survey9. Only 16.0% of married women in a Pakistani research reported using a modern method; the most prevalent method was the condom. Additionally, the percentage of female sterilization (4.0%) was higher than the percentage of male sterilization (1%).10. As the use rose from 43% among primary-educated women to 70.0% among secondary and higher-educated women, Shah's study also found that women's education was a key variable.

The contraceptive prevalence rate of Baltistan is 8.5% only, which is much low from rest of Pakistan and important reasons for not using contraceptive measures were that family planning was considered against religious, besides illiteracy, poverty and poor communication.

However awareness got from different sources as per hospital study in nepal 55.6% people got informed by media, 22.5% by health worker and 33% by relatives, in our study 35.1% informed from government hospitals, 56.4% got information from health workers while 5.9% by their friends, relatives seeking knowledge subjects were 2.6%. Health worker efficiency is seeing in our study as compared to Nepal study.

Knowledge about availability of contraceptives government hospital receiving subjects are 21.6%, primary health care provides up to 30.8%, pharmacy service provides 28.6% and private hospitals provide 28.6% contraceptives.

Currently using family methods by the subjects are 26.4% IUCD, 13.6% injectable, implant method using by 14.7%, pills using subjects are 30.8%, condom users are14.7%.(5) **:** In our survey, the majority of the women (54.0%) were familiar with more than five approaches.

Compared to Korea, where 85.0–100.0% of women had heard of five different approaches, this number is lower. Twelve Depo provera came in first place (78.0%) out of the ten contraceptive methods mentioned, followed by oral contraceptive tablets (74.0%) and condoms (71.0%).

Among the least popular techniques were emergency contraception (12.0%) and the natural method (16.0%).

In contrast to the high level of awareness, the current study revealed a very low use of FP approaches. While only 33.5% of the women were currently using one of the FP procedures—of which depo provera was the most popular—and female sterilization was more prevalent than male sterilization, 65.0% of the women had never used any methods at all.

The practice was most prevalent among urban women, Lama/Sherpa Tamang, business-employed women, women aged 20–34, women with more than a secondary education, and women with more than two living issues. Only 6.0% of respondents were currently utilizing a method, and only 3.5% were using a modern method, according to the Nigerian Demographic Health Survey.

Conclusion

Family planning is very important in this over populated world especially in fast growing populated country Pakistan. Different sources working on awareness about family planning, lady health workers are more involve in the awareness which is highly appreciated. Oral contraceptive pills are abundantly using method in this study. More awareness is required about side effect and contraindication of this method.

Recommendations

Availability of different contraceptives at government hospitals is required

Lady health workers are required to be more resourceful about contraceptives, different family planning methods their side effects.

Involvement of community in different seminars, media sessions, group discussions for awareness about family planning, its intensive need.

Involvement of local ullama and khtibs to guide community about family planning need and importance.

Strength and Limitation

This study will provide statistics for future policymakers.

Its limitation is that cannot have covered all the papulation and all parameters.

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