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FACTORS INFLUENCING UTILIZATION OF FAMILY PLANNING SERVICES AMONG FEMALE OF REPRODUCTIVE AGE IN LADY AITCHISON HOSPITAL LAHORE PAKISTAN

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Abstract

Background: *Women across the globe express concerns about the well-being of their partners and children, often playing a pivotal role in shaping reproductive attitudes and decisions on contraceptive use. Notably, Pakistan is experiencing a higher growth rate (1.8%) compared to other nations, potentially making it the most populous country in the world in the coming years.*

Objectives: *To assess the utilization and evaluate the factors which influence the utilization of family planning services among female of reproductive age.*

Methods: *Descriptive cross sectional was conducted in tertiary care hospital, lady Atchison Hospital Lahore. Data was collected from the study participants with help of questionnaire. Data were analyzed with the help statistical tests chi-square using p less than 0.05*

Result: *Most of the participants (99.1%) were married, most of the participants (38.4%) were married from 1-5 years, (43.8%) women having interval between the child was 2 years and the (42.9%) were having 3 to 4 children. This is concluded that (33.0%) women don't know about the family planning methods and (36.6%) women having no awareness about family planning methods. This is concluded that mass media highlights only (15.2%) about the awareness and learning regarding family services in the population. (26.8%) population knows about family planning methods and their sexual effects.*

Conclusion: *Some of the participants knowing about family planning methods. reasons were; they face hurdles like low income, limited awareness of available methods, and reluctance to discuss family planning. Their unfavorable attitudes contribute to moderate utilization rates and discontinuation of methods. The study emphasizes the need for comprehensive education, economic empowerment, and community engagement tailored to address socio-economic and cultural barriers in promoting family planning acceptance and utilization.*

INTRODUCTION

Family planning services provide educational, medical, and social support to help individuals decide on the number and timing of their children. These accessible and affordable services extend beyond contraception, promoting informed choices in sexual and reproductive health to ensure children are raised with agreed-upon resources, including time, finances, and social support (1).

Family planning and contraceptive programs play a vital role in national and human development. They help regulate population growth that brings about socio-economic benefits such as decreased poverty levels, enhanced education opportunities, and reduced gender inequality (2). These include methods such as female sterilization, male sterilization, oral contraceptives such as pills, Intra-Uterine devices (IUD), injectable, implants, male condoms, female condoms, and withdrawal methods (3).

Maternal mortality rates have risen significantly, with most deaths occurring in low-resource areas. In 2017, an estimated 295,000 women died during pregnancy and childbirth, with 94% of these deaths in low-resource settings, primarily in Sub-Saharan Africa, which accounted for about two-thirds (196,000) of global maternal deaths (4). Although family planning can reduce maternal deaths by 32% and child deaths by 10%, access in Sub-Saharan Africa remains low. Global initiatives now focus on expanding contraception access to achieve universal reproductive health care, aligning with the 2030 Sustainable Development Agenda (3, 5).

Family planning services, especially for child spacing, are vital for reducing maternal deaths, with developing countries accounting for 99% of global maternal deaths—Nigeria alone contributing 10%. These services help prevent unsafe and illegal abortions, which led to approximately 74,000 women's deaths in 2009, according to the UN Population Fund (6). By decreasing unintended pregnancies, family planning enhances women's reproductive health and reduces risks associated with pregnancy and childbirth in challenging conditions. Overall, family planning is a life-saving measure that benefits women, children, and society as a whole (1, 7)

Multiple studies have linked low contraceptive uptake to factors such as limited awareness of available family planning services, insufficient information about different methods and their functioning, and inadequate counseling on potential side effects (8). Structural barriers, such as long distances to healthcare facilities, unavailability of preferred methods, policy limitations, and undesirable provider attitudes, also impede service utilization. Additionally, individual-level barriers encompass perceptions of risk, reactions to contraceptive use, and a lack of knowledge necessary for making informed choices (9).

Understanding a woman's future needs and increasing her likelihood of converting intentions into action is crucial when considering contraceptive methods. Behavioral intentions, widely believed to predict behavior, are often used to assess program effectiveness in various interventions, including those for contraceptive use. Recognizing women's access to life-saving contraception as a human right is essential (10). A person's intention to engage in a behavior is influenced by perceived costs and motivation. The intention to use contraceptives is a key factor in controlling family size, preventing unnecessary pregnancies, and improving the health of children, women, families, and societies. In sub-Saharan Africa, challenges such as unintended pregnancies, high fertility rates, and abortion persist among women of reproductive age (11)

Family planning, as defined by WHO, helps individuals achieve their desired number of children and improve maternal health outcomes, significantly reducing maternal and child mortality rates. Initiatives in developing countries emphasize family planning to space pregnancies and prevent unintended pregnancies, which can help address the global crisis of unsafe abortions. Despite its benefits, modern contraceptive methods are underutilized in these regions, leading to increased maternal deaths and burdening healthcare systems (12, 13).

Women worldwide are deeply concerned about their partners' and children's well-being, influencing reproductive attitudes and contraceptive decisions. Pakistan's growth rate of 1.8% may soon make it the most populous country, exacerbating challenges in resource availability and reproductive health since

independence (14). Many families in developing countries remain unaware of family planning. While early programs focused on men, there is now a recognition of women's critical role in these initiatives. Thus, assessing women's knowledge and attitudes toward family planning is essential, and this study aims to evaluate these factors among women of reproductive age.

Material and Methods:

This descriptive cross-sectional study, conducted over four months at Lady Aitchison Hospital, Lahore, focused on women aged 15-45 using family planning services. A sample of 112 was calculated using the Cochrane formula with a 92% confidence level and 8% margin of error, and selected via systematic random sampling. Inclusion criteria were local married women, while exclusions included those unwilling to participate or with cognitive or medical limitations. Data was gathered through face-to-face interviews using a self-structured questionnaire covering demographics, knowledge, family planning utilization, and influencing factors. Data analysis, conducted in SPSS and Excel, utilized descriptive and inferential statistics, including chi-square tests to identify significant associations at $p < 0.05$.

Results

Table no 1: Demographic variable of the study participants

		n	%
Age in Years	15-24	29	25.9
	25-34	57	50.9
	35-44	23	20.5
	45-54	3	2.7
Religion of Client	Islam	103	92.0
	Christianity	9	8.0
Academic Attainment	Primary Education	47	42.0
	Secondary Education	20	17.9
	Tertiary Education	12	10.7
	No Education	33	29.5
Occupation of Client	Civil Servant	9	8.0
	Full House Wife	102	91.1
	Student	1	0.9
	Total	112	100.0

Analyzed by frequency n and percentage %

Table 1 summarizes participants' demographics: 50.9% were aged 25-34, and 92.0% were Muslim. Educational levels varied, with 42.0% having primary education, and most (91.1%) were housewives. Data analysis used frequency and percentage to provide these demographic insights.

Table 2: Demographic variable of the study participants

		n	%
Marital Status	Married	111	99.1
	Divorce	1	0.9
If Married how Long	1-5years	43	38.4
	6-10 Years	29	25.9
	11-15 Years	25	22.3
	16-20 Years	15	13.4
	1 Years	29	25.9
Interval Between	2 Years	49	43.8

Children	3 Years	34	30.4
	1-2 Children	42	37.5
Number of Children	3-4 Children	48	42.9
	5 Above	22	19.7
	Total	112	100.0
Analyzed by frequency n and percentage %			

Table 2 outlines the demographics of participants, with 99.1% being married. The largest proportion (38.4%) had been married for 1-5 years. Regarding child spacing, 43.8% had a 2-year interval, and 42.9% had 3-4 children. Smaller groups included those married for 6-10 years (25.9%) or 11-15 years (22.3%), and those with 1-2 children (37.4%) or over 5 children (19.7%). Data analysis utilized frequency and percentage to provide a demographic profile.

Table no 3: Participants know about family planning and the method they used.

		n	%
Have you heard about family planning	Yes	75	67.0
	No	37	33.0
Tick the family planning method you know?	1-2 Methods	34	30.4
	3-4 Methods	34	30.4
	All Methods	3	2.7
	No Awareness	41	36.6
	Total	112	100.0
Analyzed by frequency (n) and percentage (%)			

Table 3 reveals that 67.0% of participants had heard of family planning, while 33.0% had not. Familiarity with specific methods varied: 30.4% knew 1-2 methods, another 30.4% knew 3-4 methods, and only 2.7% were aware of all methods, with 36.6% having no knowledge of any methods. This indicates that 33.0% of women lack awareness of family planning, and 36.6% are unfamiliar with specific methods.

Table no 3: Participants where did you first learn about family planning and sexual urge

		n	%
Where did you first learn about family planning methods?	None	10	8.9
	Hospital	48	42.9
	Mass Media	17	15.2
	Friends & Family	37	33.0
Does family planning decrease sexual urge?	None	9	8.0
	Yes	30	26.8
	No	73	65.2
	Total	112	100
Analyzed by frequency (n) and percentage (%)			

Table 3 shows sources of participants' first learning about family planning and perceptions of its effect on sexual urge. Hospitals were the main source (42.9%), followed by family and friends (33.0%), and mass media (15.2%). Regarding whether family planning decreases sexual urge, 65.2% said "No,"

26.8% "Yes," and 8.0% "Other." The data suggest that only 15.2% learned about family planning from mass media, and 26.8% are aware of its potential effects on sexual urge.

Table No 4: Family planning methods prevent STI and type of services rendered in family planning clinics

		n	%
Do some of the family planning methods prevent STI?	None	10	8.9
	Yes	62	55.4
	No	40	35.7
Do you know the type of services rendered in family planning clinics?	None	3	2.7
	Yes	61	54.5
	No	48	42.9
	Total	112	100

Analyzed by frequency (n) and percentage (%)

The table reveals participants' awareness of family planning's role in STI prevention and familiarity with services offered at family planning clinics. Regarding STI prevention, 55.4% responded "Yes," 35.7% "No," and 8.9% selected "Other." Familiarity with clinic services showed 54.5% were aware, 42.9% were not, and 2.7% chose "Other." Analysis using frequency and percentage highlights that 35.7% lack awareness of STI prevention through family planning, and 42.9% are unfamiliar with clinic services.

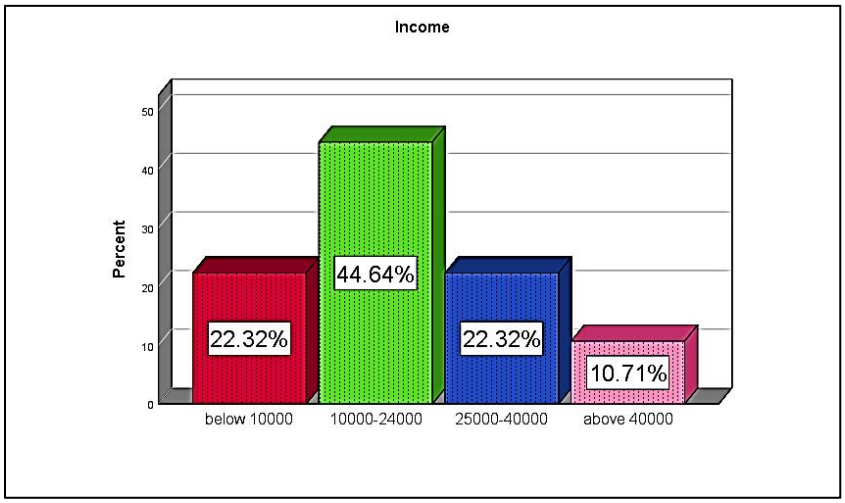

Figure 1: Family Income of the study Participants

This figure 1 represent the family income of the study participants those who had income below 10,000 were 22.32%, 10,000 to 24000, 44.64%, 25000 to 40,000 22.32% while 10.71% had a family income greater than 40,000 rupees

Discussion

This study concluded that most of the study participants (50.9%) were in the age between 25 to 34 years. On the base of religion, the majority of participants (92.0%) were Muslim, with having primary education (42.0%) and the majority 91.1% of participants were housewives 43.8% women having interval between the child was 2 years and the 42.9% were having 3 to 4 children. According to the study of Olatade MJ and colleague majority (41%) of the participants were within 25-34yrs of age whilst (7%) of the participants were within 45-54 years. Islam is the religion (84%) practiced by most of the participants. Participants were mainly educated to

tertiary level (58%). However only a few percentages were unemployed full-time housewives (12%). Majority of the participants earned less than 10,000 (35%) and there were mostly single unmarried females (57.3%) (15)

Similarly the finding of Olatade and colleague shows that majority of the respondents 53.5% were between ages 15-25, 62.8% had secondary education, 76.7% married, 81.4% Christians, 48.8% traders, 79.1% earn below 30,000 naira as their average monthly income, 39.5% have just 1 child per household and 74.4% are aged between 19-30 years at first pregnancy (16)

The present study concluded that (33.0%) women don't know about the family planning methods and (36.6%) women having no awareness about family planning methods. Furthermore 15.2% participants said that the awakened and know regarding family services in the population through mass media. (26.8%) population knows about family planning methods and their sexual effects. (35.7%) didn't know that family planning methods prevent sexually transmitted infections. (42.9%) people did not know about the services rendered in family planning clinics.

However, the study of Duru and colleague reported that awareness and knowledge about family planning in both localities were high, the overall family planning use was low. Also, family planning use was higher among women from urban communities than those from rural communities of the State. These findings may have implications for public health policies and programs especially at the grass roots. Thus, there is need for stake holders in the State to find ways of increasing the use of family planning services by making it attractive to these women through incentives especially among those living in the rural areas of the State (17).

According to the report of Oluwasegun and Colleague although the respondents had fairly good knowledge of family planning, the study observed some misconceptions especially with respect to side effects and methodology of use of the commodities. Low uptake of family planning was observed among the respondents. Age and marital status were significantly associated with family planning knowledge; level of education was significantly associated with current use of family planning (18)

Additionally, the report of Nagudi and Esther showed that the Family planning (FP) has numerous benefits for the mother, the children, the family and society at large. All policies and programs aimed at encouraging women of childbearing age in the community to seek family planning services should be encouraged (19).

Similarly, the report of Abiodun and colleague showed that utilization of family planning was fair with good knowledge but the practice was limited mostly by personal and socio-cultural factors. Therefore, improved mass education strategies and men involvement in family planning is recommended. Adequate public education should be intensified with focus on personal and socio-cultural factors with active men and community stake holders' involvement in family planning issue for improved utilization of family planning (20).

In the same context the finding of Slater and colleague demonstrated that more than half of the respondents had adequate awareness and nearly half of the respondents were current family planning users. There is no association between the level of awareness and practice of family planning. It provides baseline data of the respective area. Health personnel and responsible authorities will be sensitive to increase awareness and optimize the utilization of family planning. Further large-scale studies are needed to identify barriers to using family planning methods (21).

The study of Schwandt and colleague found that 22.32% of participants had a family income below 10,000, and 58% were aware of family planning, primarily informed by health workers (70.8%). While 78% recognized some methods, especially condoms (45%), 70% would not advise female friends to use family planning, and decision-making largely rested with males (82.3%). Despite good knowledge of methods, unfavorable attitudes led to low utilization and discontinuation rates of family planning services (22).

Conclusion:

This study highlights key demographics and dynamics in family planning awareness and usage, showing that most participants, aged 25-34, were Muslim, with primary-level education, and were primarily housewives. Many had a reproductive

pattern of two-year intervals and three to four children. Although participants were generally aware of family planning, practical use faced barriers like low family income, limited knowledge of available methods, and reluctance to discuss family planning socially. Attitudes toward usage were often unfavorable, leading to moderate adoption and occasional discontinuation. The findings suggest that to enhance family planning acceptance, tailored interventions should address educational, economic, and socio-cultural factors through comprehensive community-based strategies.

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