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Practice of Contraception and Quality of life among Bhutanese Refugee Women of Eastern Nepal

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Practice of Contraception and Quality of life among Bhutanese Refugee Women of Eastern Nepal

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Conclusion: Owing to the patriarchal society of Bhutanese refugee of Nepalese origin, male participation for use of family planning was found less. The females were found to be using family planning methods, though the decision resided on the male counterpart.

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I. Introduction

Use of family planning methods have prevented many unintended pregnancies and improved the quality of life by improving the overall maternal health and decreasing the burden of uncontrolled fertility. However, the use of contraception isn't consistent throughout the world; it ranged from as high as 80% in developed countries and as low as 12% in Sub-Saharan Africa.[1] Most of the consumers and target client of family planning programme are women from provider perspectives. Men involvement in family planning use for planning a family is very less. Belief, culture and social structure affect the use of contraception. Study from Kuwait found that husband's opinion and views towards adoption of family planning methods had a large impact on contraceptive behavior.[2] The current prevalence of contraceptive use is approaching to 60% worldwide, 53% in less developed countries and 43% in Nepal.[1, 3, 4] The health center launches programme to increase knowledge of contraception through information, education and communication programmes by community health workers in the refugee community. Measuring the level of awareness of contraception provides a useful measure of the success of information, education and communication activities and helps to identify the areas of need to be strengthened.[5] The contraceptive methods not available in the health centers like sterilization, IUCD (Intrauterine contraceptive devices) are made available to the consumers by sending them to the referral centers nearby as per the understanding with UNHCR.

Bhutanese refugees are staying in eastern part of Nepal after they fled from their country almost two decades back. They live in camps and use the resources provided to them by various programme implementing agencies of United Nation High Commission for Refugees from providers perspectives.

The combined oral contraceptive (COC) pills, injectable and intrauterine contraceptive devices (IUCD) are the most common contraceptive methods used by women. Women's choice, compliance and satisfaction with specific contraceptive methods are influenced by impact of the method on their quality of life and sexual function.[19]

This study was carried out to assess the knowledge, practices and their quality of life from user's perspectives. To our knowledge this study is the first of its kind done among Bhutanese refugees regarding their contraceptive practices and its impact on their quality of life.

II. Materials & Methods

This was a cross-sectional study conducted among the Bhutanese refugee camps of Jhapa district

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of Eastern Nepal from July 2011to July 2012. Collected data were entered into MS Windows Excel in the form of codes. Analysis was performed using Statistical Package for Social Sciences (SPSS) 17.0 version. Ethical clearance was obtained from the ethical committee of B. P. Koirala Institute of Health Sciences prior to the study. Informed consent was taken from all the participants and confidentiality was maintained to the information collected.

This study investigated the contraceptive awareness, practices and its impact on their quality of life among the married women of reproductive age group (15 – 49 years) in Bhutanese refugee population residing in the eastern part of Nepal. Sample size calculation indicated that a study of 350 subjects was adequate to achieve a high degree of precision (95%) based on a study done in Karimnagar, India by Kameswararao Avasarala which showed that contraception users had better quality of life.[6] The study sample was recruited among full time residents of refugee camp by using systematic random sampling. Variables like participants with family members in third country settlement, living outside the camp, not consuming the resources of the camp were excluded which could directly affect the quality of life other than using family planning methods. Data were collected by face to face interview using pretested structured questionnaire on family planning and WHOQOL BREF. It consisted 42 items that included questionnaires on family planning knowledge, their practices and quality of life as well as socio-demographic characteristics. Informed understood written consent was obtained prior to data collection from all the participants and AMDA (Association of Medical Doctors in Asia) Primary Healthcare Project for Bhutanese Refugees which catered health services to the refugees. Care was taken to keep the questionnaire response anonymous and confidential. Only married women of reproductive age group were considered for the study as use of family planning methods as sex life related WHOQOL questionnaire were not appropriate for refugee society where premarital sex is prohibited and considered to be a sin.

The definition of contraceptive users was use of any method of contraception by the respondents or the partner with the aim of controlling the birth. The 'current user' was the use of contraception continuously for the last twelve months and the non-user was non adoption of contraception for the last twelve months.

Data was entered in Excel software and analyzed using the Statistical Package for Social Sciences (SPSS Inc. 17.0 Version). The WHOQOL domain scores were calculated using the WHOQOL BREF syntax and Student t test was applied wherever appropriate. For all the analysis, a P - value less than 0.05 was considered to be significant.

III. Results

A total of 350 married women of reproductive age group were included in the study and table 1 shows the selected socio-demographic characteristics of the respondents.

Table 1 : Sociodemographic Characteristics of the respondents (n = 350)

Variables	Frequency	Percentage
Age group (Years)		
15 – 19	26	7.4
20 – 24	83	23.7
25 – 29	91	26.0
30 – 34	58	16.6
35 – 39	62	17.7
40 – 44	12	3.4
45 - 49	18	5.1
Education		
Illiterate	122	34.9
Literate / Primary	158	45.1
High School	70	20.0
Occupation		
Unskilled	298	85.1
Semiskilled/ Skilled	52	14.9
Religion		
Hindu	257	73.4
Buddhist	75	21.4
Christian	18	5.1
Poverty Line		
Below Poverty Line	342	97.7
Above Poverty Line	8	2.3

Among the participants, majority (87%) were aware about the free provision of family planning methods in the health center but still 13% of them didn't know about this. Depo-Provera, oral pills and male condoms were known to all. Study revealed 62.3% current users of contraception. (Table 2)

Table 2 : Awareness and Practices regarding various contraceptive methods among the respondents (n = 350)

Variables	Frequency	Percentage
Awareness about free contraception		
Yes	304	86.9
No	46	13.1
Awareness about types of contraception *		
Depo-Provera	350	100.0

Oral Contraceptive Pills	350	100.0
Male Condom	350	100.0
Female Condom	266	76.0
Norplant	180	51.4
IUCD	171	48.9
Male Sterilization	151	43.1
Female Sterilization	53	15.1
Abstinence	48	13.7
Current use of Contraception		
Yes	218	62.3
No	132	37.7

** Multiple Responses*

Depo-Provera was the most popular method among the refugee women (57.3%) followed by oral pills (23.3%) and male condom (11.0%) respectively and two of the respondents practiced abstinence as contraception. (Table 3)

Table 3 : Types of contraception used by current users (n = 218)

Variables	Frequency	Percentage
Types of contraception used		
Depo-Provera	125	57.3
Oral Contraceptive Pills	51	23.3
Male Condom	24	11.0
Female Condom	12	5.5
Norplant	4	1.8
Abstinence	2	0.9

Among the non-users, husband's disapproval was found to be the main reason followed by lack of knowledge (37.1%). Substantial proportion had reason of religious belief (22.8%) for not using contraception. (Table 4)

Table 4 : Reasons behind not choosing family planning methods (n=132)

Variables	Frequency	Percentage
Reasons behind not opting for contraception		
Husband's Disapproval	53	40.1
Lack of Knowledge	49	37.1
Religious Beliefs	16	22.8

Scores from WHOQOL questionnaires were obtained in five domains: the overall, physical, psychological, social and environmental domains. It was observed that all the domain scores of quality of life except environmental domain score were significantly higher among contraceptive users than the non-users. Similarly, significant scores in all the domains of quality of life were found among the respondents with knowledge of free availability of contraception in the health center. (Table 5)

Table 5 : Association between WHOQOL and contraception users and non - users (n = 350)

Domains	Yes	No	P value
	Mean (SD)	Mean (SD)	
Current Contraception Users			
WHOQOL domains			
Overall Domain	65.3 (12.3)	62.2 (8.5)	0.01
Physical Domain	9.7 (1.8)	8.6 (1.3)	< 0.001
Psychological Domain	10.3 (2.5)	10.0 (1.9)	0.19
Social Domain	10.8 (2.8)	9.7 (2.1)	< 0.001
Environmental Domain	9.8 (1.9)	9.9 (1.4)	0.825
Knowledge of Free availability of Contraception			
WHOQOL domains			
Overall Domain	62.4 (10.4)	66.0 (11.5)	0.003
Physical Domain	9.4 (1.7)	8.6 (1.7)	0.002
Psychological Domain	10.4 (2.3)	9.1 (1.6)	< 0.001
Social Domain	10.6 (2.6)	9.3 (2.1)	0.002
Environmental Domain	10.0 (1.7)	9.0 (1.4)	0.001

IV. Discussion

This study provided information about the knowledge, practice and quality of life of contraception adopters among the married women of reproductive age group in Bhutanese refugee population. Quality of life has been defined as an individual's perceptions of their position in life in the context of the culture and value systems in which they live in and in relation to their goals, expectation, standards and concerns (WHO).[18]

The mean age of our study was found to be 29.3 years which is also comparable to Nepal Demographic and Health Survey 2011.10Similarly, there was a predominance of Hindu by religion among the participants which was comparable to Nepalese society.[10] This shows that Bhutanese refugee population who are of Nepali origin had maintained their cultural and religious integrity despite of emigration long before. Almost thirty five percent of the respondents were illiterate which was lower than the literacy rate of eastern hills of Nepal.[10] This could possibly be due to lack of utilization of free education during the refugee status acquisition. Refugee populations were required to live in camp full time and utilize the resources provided by various programme implementing agencies. Work outside the camp is prohibited. Therefore around 85.1% of them were found to have unskilled occupation with predominance of housewives. This was further reflected by poverty status where 97.7% of them were below poverty line (Table 1).

Among them, all were aware about Depo-Provera, oral contraceptive pills and male condom which was similar to a study done in UAE by Ghazal – Aswad et al and NDHS report 2001, 2006 and 2012.[10, 11, 12] This could possibly be due to vigorous health information, education and communication programmes conducted within the camp by the health center. Though, all the services were provided free of cost for the refugees, it was surprising that, 13.1% of the participants were not aware about the contraception available free of cost in the health center. This was one of the noticeable feedbacks from user perspective. This clearly showed community health programmes haven't penetrated every segments of the refugee population. This would have never known to us from a study done from provider perspectives.

More than half were using Depo-Provera (57.3%) followed by oral contraceptive pills (23.3%) and male condom (11.0%). The reason behind Depo-Provera being a popular method could possibly be due to the fact that one shot of it worked for three months; privacy was ensured about the use, easily available and can be used even without the consent of husband or family members. This finding was also constitent in a study done by Bhattarai D where Depo-Provera was the most used contraception.[13] The type of contraception use showed that females were mostly the ones who used contraception to plan a family rather than the husband. Refugee population having a patriarchal society influenced by male child syndrome required females to use family planning methods as per the advice of their husbands and take the responsibility for the family; though the decision making right resided among the husbands. This predominance of husband's influence over their wives uptake of family planning method was also noted in studies by Family Health International and Poudel IS.[14, 15] Vasectomy wasn't reported in our study and this is relatively less among the families in south Asian region.[14] It clearly showed less male participation regarding the use of contraception which is common in south Asian communities where dominance of men over women is common. If men were supportive as equal partners and responsible partners better outcomes were expected in reproductive health indicators like contra-ception acceptance and continuation which is vital to improve overall maternal health.[7]

Husband's disapproval (40.1%) was found to be the main reason in our study for not using contraception. More than one fifth (22.8%) of the respondents didn't use contraception due to religious beliefs in (Table 4). This attitude against family planning was common and hinted the strong presence of traditional and conservative social practices and beliefs among some upper caste in Hindu religion. Use of contraception led to irregular bleeding which prevented them from performing scared religious rituals and sexual activities. These activities are absolutely prohibited during menstruation as women are considered to be 'impure' during these days. This type of practice was also observed in Islam countries where women weren't allowed to pray or participate in sexual activities during menstruation.[3, 8, 9]

It was observed that, quality of life was better among contraceptive users as compared to non-users and better among women with knowledge of availability of free contraception which is similar to the study done in India by Kameswararao, India.[6] This could be due to the absence of the fear of having unwanted pregnancies and gradual improvement overall maternal health. Consistent and proper use of family planning methods helped couple to plan a family and maintain financial and social stability gradually. Similar finding was also reported in the study done in by C. Egarter et al. among oral contraceptive users.16In a study done in Hong Kong, no adverse impact was noted by use of contraception upon the quality of life and sexual function of users.[17]

The major weakness of this study: the instrument of this study is based on consumer perspective's which is liable for subjective bias. To our knowledge, this was the first kind of study among the Bhutanese refugee population from consumer's persp-ectives. Consumer perspectives have an added benefit

of increased community participation and are essential for any program's success.[19]

V. Conclusion

Though all the participants were aware about contraception, more than one tenth of them weren't aware about the free provision of its availability within the health center in their respective camp. Lack of men's participation for adopting contraception led to more use of contraception among the females. Better quality of life was observed among contraception users possibly due to proper and consistent use of contraception which led to a well-managed family and life devoid of fear for unwanted pregnancies.

VI. Ethical Considerations

Ethical issues (Including plagiarism, Informed Consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc) have been completely observed by the authors. No Competing interests among the authors.

VII. Acknowledgement

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