UNIVERSITI SAINS MALAYSIA

FAMILY PLANNING: ATTITUDES AND PRACTICES AMONG POSTNATAL WOMEN AND THEIR HUSBANDS IN OBSTETRIC AND GYNECOLOGY CLINIC, HOSPITAL UNIVERSITI SAINS MALAYSIA (HUSM)

by

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Dissertation submitted in partial fulfillment of the requirements for the degree of Bachelor of Health Sciences (Nursing)

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CERTIFICATE

This is to certify that the dissertation entitled Family Planning: Attitudes and Practices among Postnatal Women and Their Husbands in Obstetric and Gynecology Clinic, Hospital Universiti Sains Malaysia (HUSM) is the bonafide record of research work done by Nor Idzziana Baser, 87442 during the period of July 2008 to April 2009 under my supervision. This dissertation submitted in partial fulfillment for the degree of Bachelor of Health Sciences (Nursing). Research work and collection of data belong to Universiti Sains Malaysia.

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ABSTRACT

Lack of awareness towards family planning among men and women is an issue needed to take into account. This quantitative study was conducted to identify the relationship between attitudes and practice of family planning among men and women in Obstetric and Gynecology Clinic, HUSM. This research is a cross-sectional, descriptive study using questionnaire. The sample is 65 men and women selected from Obstetric and Gynecology Clinic, HUSM. Self-administer questionnaire was utilized and the questionnaire consists of three sections. Section A consists of respondent's demographic characteristics, Section B consists of 26 attitudinal statements and Section C consists of one question regarding contraceptives practice. Data was analyzed by Chi-square test from Statistical Package for Social Science (SPSS) version 12 software. More than half of the men and women had positive attitudes towards family planning, but yet only minority of them uses contraceptives method. These quantitative findings contrast with results from other research in other countries. Educated men and women's tend to practice family planning due to their knowledge to the use of contraceptives. Men and women who wanted more children were reluctant to practice family planning. Understanding family planning thoroughly is the key concept in practicing it. Throughout this study, sociocultural and traditional norms give a huge impact on practice of family planning. Therefore, intervention efforts should address these issues and mold action plans appropriate to the situation.

PERANCANGAN KELUARGA: SIKAP DAN AMALAN DALAM KALANGAN WANITA POSNATAL SERTA SUAMI DI KLINIK OBSTETRIK DAN GINEKOLOGI, HOSPITAL UNIVERSITI SAINS MALAYSIA (HUSM)

ABSTRAK

Kurangnya kesedaran terhadap perancangan keluarga dalam kalangan lelaki dan wanita merupakan satu isu yang perlu diberi perhatian. Kajian kuantitatif ini dijalankan bertujuan mengenalpasti hubungan antara sikap dan amalan perancangan keluarga dalam kalangan lelaki dan wanita di Klinik Obstetrik dan Ginekologi, HUSM. Kajian jenis deskriptif ini menggunakan soal selidik. Sampel kajian adalah seramai 65 orang lelaki dan wanita yang hadir ke Klinik Obstetrik dan Ginekologi, HUSM. Responden dikehendaki menjawab soal selidik berkenaan perancangan keluarga yang mengandungi tiga bahagian: Bahagian A mengandungi data demografik, Bahagian B mengandungi penyataan berkenaan sikap dan Bahagian C mengandungi satu soalan berkenaan amalan kontraseptif. Data-data telah dianalisis menggunakan ujian Khi Kuasa Dua daripada perisian Statistical Package for Social Science (SPSS) versi 12. Lebih daripada separuh responden mempunyai sikap yang positif terhadap perancangan keluarga, namun hanya sebahagian kecil sahaja yang menggunakan kontraseptif. Hasil kajian ini bersifat kontra daripada hasil kajian daripada negara lain. Lelaki dan wanita yang berpelajaran lebih cenderung untuk mengamalkan perancangan keluarga berikutan pengetahuan mereka mengenai penggunaan kontraseptif. Lelaki dan wanita yang inginkan lebih ramai anak lebih keberatan untuk mengamalkan perancangan keluarga. Kefahaman yang menyeluruh merupakan kunci utama untuk mengamalkan perancangan keluarga. Berdasarkan kajian ini, faktor sosiobudaya dan norma-norma tradisional

memberikan impak yang besar terhadap perancangan keluarga. Jadi, isu ini perlu dititikberatkan dan plan aksi yang sejajar dengan situasi ini perlu dibentuk.

CHAPTER 1

INTRODUCTION

1.1 Background of the Study

The world population is growing rapidly. In mid 2007, the population in more developed countries is 1221 millions and in less developed countries it exceeds 5400 millions. Among the countries, China (1318 millions) is the most populous country, followed by India (1312 millions), United States (302 millions) and Indonesia (232 millions). In mid 2050, the projected population in the world is expected to exceed 9200 millions populations. In Malaysia, the population in mid 2007 is 27.2 millions people and is expected to increase until 40.5 millions in mid 2050 (Population Reference Bureau, 2007). When population is greater, mankind is in for a greater risk of poverty, diseases and suffering. When we realize about these worrying phenomenon, we can easily acknowledge that the problem is at peak that it had to be aggressively addressed and resolved.

In concordance with the burden of the increasing world population, World Population Day 2008 focal point will be on family planning; with the magic word "Family planning- it's a right, let's make it real" (WHO, 2008). Pregnancy is particularly risky to certain groups of women; very young women, older women, women with more than four children, and women with existing health problems. If all high risk pregnancies were prevented, maternal mortality could be reduced by up to 25% (Wang, 1989). There are women of childbearing age around the world who wants to plan their pregnancy, but most of them didn't use any method of contraception and the remaining use less effective traditional methods. Prompt use of contraception can help lengthen the interval between births, preventing serious complications to both women and her children (UNFPA, 2006). These will in hand reduce the maternal and infant mortality rate.

The history of modern contraception probably began with the invention of condom (Gelber, 1964). Condom; a thin rubber sheath worn on the penis, act as barrier method of contraception. Plummer, Wight, Wamoyi, Mshana, Hayes, and Ross, (2006) in their study recognized that the negative attitudes towards condom make it's used exceedingly rare; the alien nature of condoms; the association of condoms with infection, promiscuity, and reduced sexual pleasure; and the difficulty of accessing condoms due to embarrassment or distance.

Thanks to the rapid transformation and the new development in research of hormonal contraception, an immense variety of contraception is available nowadays with a number of new routes of administration. Today contraceptive hormones can be administered orally, intramuscularly, intrauterus, intravaginally, subcutaneously and transdermally. Oral Contraception (OC) remains the most important and widely accepted types of contraception. New effort to improve OC lead researchers to encountered with dose reduction OC pill. Dose reduction estrogen OC can minimize estrogen-related side effects such as breast tenderness, bloating, and nausea. Whereas dose reduction progestin OC acted negatively on lipid metabolism; which makes it specifically indicated in women who, when using OCs, complain of fluid retention or weight gain (Benagiano, Bastianellil, & Farris, 2006).

Contraceptive intravaginally is the contraception method whereby contraceptive rings to be inserted in the vagina. It uses the well-known ability of the vaginal epithelium to absorb a large variety of different substances (Hussain & Ahsan, 2005). Examples of intravaginal contraceptive are estrogen-progestin vaginal ring (EP-VR) and progestin vaginal ring (P-VR). Contraception intradermally is the introduction of contraception hormonal via the skin. In transdermal delivery, the contraceptive patch is applied either to the upper outer arm, upper torso excluding breast, buttock, or lower abdomen.

Intrauterine device (IUD) release contraceptive hormonal directly in utero. It is capable of exerting good contraceptive activity without inhibiting ovulation (Carenza,

Ermini, Pala, & Benagiano, 1976). The modern IUD known as LNG-IUS is a system that combines the advantages of oral and intrauterine contraception; very effective and reversible. Follow-up studies of women in randomized trials prove that mean time to pregnancy is 4 months after removal of the device (Andersson, Batar & Rybo, 1992). Forrest and Fordyce (1993) in their study revealed that women who use IUDs report very high levels of satisfaction with their method and these findings may indicate that side effects are well tolerated overall. Recent researches move one step further with the invention of non-hormonal frameless IUDs; a simple IUD without plastic frame. The simple design is intended to cause less pain and bleeding than framed devices (O'Brien & Marfleet, 2005).

Monthly estrogen-progestin injectable (MEPI) is contraceptives via intramuscular. The primary mode of action of MEPIs is the suppression of ovulation. In addition, they produce thickening of cervical mucus, which becomes an obstacle to sperm penetration (Benagiano, Bastianellil, & Farris, 2006). According to Bertrand, Seiber and Escudero (2001), injectable method had become more acceptable worldwide in the 1990s due to its increasing availability. Subcutaneously implanted contraceptives work primarily by thickening cervical mucus, prevent ovulation in many cycles and suppress endometrial growth and maturation (Benagiano, Bastianellil, & Farris, 2006). According to Tanfer (1994), the implant has become an attractive method for young women, who already have a child and who want either to postpone their next birth indefinitely or to stop childbearing altogether. Modern research focus on more potent implants; that can minimize side effects, mainly bleeding disturbances; and implants that are safe for use while breastfeeding.

Access to family planning and the ability to decide when and how many children to have will empower women; to overcome traditional gender roles and increase their level of education, which most often leads to better health outcome. In the other hand, access to family planning can also increases a family economical status, slow population growth and ease the pressure on the environment.

1.2 Problem Statements

A National Family Planning Program was launched in Malaysia in 1966. The main objective of the program was to improve family health and welfare through voluntary acceptance of family planning. A survey prior to the program showed that 70% of married women of childbearing age in Malaysia agreed with family planning and that 36% did not want any more children. Among those who wanted to stop childbearing, only 22% didn't employ any contraceptives. In 4 years time following the launching of the National Family Planning Program, the percentage of family planning almost doubled; from 14% in 1966 to 27% in 1970 (Wang, 1989).

With the rapid industrialization in the 1980s, various sectors lack of labor forces. It was then when changes were made in the Fourth National Plan, which lead to the de-emphasized of the family planning program in Malaysia to achieve population of 70 million by 2100. As consequences, the information, communication and education programs were withdrawn; which results in declined of contraceptives used (Wang, 1989).

In 2004, only 40% of Malay women practiced family planning compared to Chinese women (65%) and Indian women (51%). A large percentage of women in Malaysia use contraceptives to space their children, rather than to limit the number of births (Wang, 2007). This shows that the governments can still achieved their plan without damaging the health of the mothers and their children. If we have sufficient populations for the labor forces, but the populations are poor in health, having economical and social problems, our country is still facing even more problems.

This study was conceptualized with the help of The Theory of Planned Behaviour (TPB), proposed by Icek Ajzen in 1985 to explain about health-related decision making. According to TPB, human behavior is guided by three kinds of considerations: behavioral beliefs, normative beliefs, and control beliefs (Ajzen, 1991).

1.3 Objectives of the Study

This study is to identify the relationship between attitudes and practice of family planning among men and women in Obstetric and Gynecology Clinic, HUSM.

1.3.1 Specific objectives

1. To identify the attitudes of men and women in Obstetric and Gynecology Clinic, HUSM regarding family planning.
2. To identify the practices of men and women in Obstetric and Gynecology Clinic, HUSM regarding family planning.
3. To examine the association between attitudes and practice of family planning among men and women in Obstetric and Gynecology Clinic, HUSM.
4. To examine the association between education level and practice of family planning among men and women in Obstetric and Gynecology Clinic, HUSM.
5. To examine the association between number of desired children and practice of family planning among men and women in Obstetric and Gynecology Clinic, HUSM.

1.4 Research Questions

1. What are the status of family planning attitudes among men and women in Obstetric and Gynecology Clinic, HUSM?
2. How are the practices of family planning among men and women in Obstetric and Gynecology Clinic, HUSM?
3. Do attitudes affect the practice of family planning among men and women in Obstetric and Gynecology Clinic, HUSM?
4. Does the education level affect the practice of family planning among men and women in Obstetric and Gynecology Clinic, HUSM?
5. Does the number of desired children affect the practice of family planning among men and women in Obstetric and Gynecology Clinic, HUSM?

1.5 Hypotheses

i. Null hypothesis, $H_0 = 0$

H_0: There is no significant association between men and women's attitudes towards family planning and family planning practice.

Alternative hypothesis, $H_a \neq 0$

H_a: There is a significant association between men and women's attitudes towards family planning and family planning practice.

ii. Null hypothesis, $H_0 = 0$

H_0: There is no significant association between education level and family planning practice.

Alternative hypothesis, $H_a \neq 0$

H_a: There is a significant association between education level and family planning practice.

iii. Null hypothesis, $H_0 = 0$

H_0: There is no significant association between the number of desired children and family planning practice.

Alternative hypothesis, $H_a \neq 0$

H_a: There is a significant association between the number of desired children and family planning practice.

1.6 Conceptual Definitions

i. Family planning

Family Planning implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility (WHO, 2007). Popov, Visser and Ketting (1993) view family planning as the use of contraceptive methods, either traditional or modern, to prevent unwanted pregnancy. Induced labor is not considered to be a family planning method.

ii. Contraceptive

Contraceptive is a device or drug used to prevent contraception.

iii. Attitude

According to Kar (1978) family planning attitudes are the attitudes toward personal used of available contraceptive methods, willing to recommend these to peers. In this research, attitude is the ability of the women of childbearing age to see, hear or become aware of family planning and contraception.

iv. Practice

Practice in this research refers to the application of knowledge regarding family planning and contraception in actual life to plan for time and spacing of children.

1.7 Significance of the Study

In the Obstetric and Gynecology Clinic at HUSM, there used to be a program for family planning. Due to lack of support from the clients, the program was cancelled. Now, family planning session is given by the family planning nurse to those who requested only. This research is expected to obtain a clear picture of family planning practice and contraceptives use. In Malaysia and in Kelantan particularly; where the majority of population is Malay and practice Islam, men usually are the decision-makers in a family. Therefore, family planning practice is highly depending on husband's attitude and approval. In order to understand the pattern of family planning practice accurately, research should be done to both men and women. Petro-Nustas (1999) in his study agrees with this statement by stated that further research should examine attitudes about birthspacing and contraceptives in greater detail, including husbands and wives simultaneously. This research is intended to view the insight of men's and women's attitudes towards family planning practice and the attitudes that oppose to them. In advance, this research is hoped to create a whole new perspective of viewing the aspect of family planning. There should be a more harmonious balance between population, development, health and welfare.

CHAPTER 2

LITERATURE REVIEW

2.1 Incidence and Prevalence

Worldwide, contraceptive utilization grew from 38% in the 1970s to 52% in the 1990s. In developing countries, the increase has been from 27% to 40%. Globally, more than 600 million married women are using contraception with nearly 500 million are in developing countries. Research also shows that utilization of modern contraception has been higher in the industrialized countries than in developing countries (Benagiano, Bastianellil, & Farris, 2006). Ethiopia is an example of African country that has shown excellent recent progress in family planning. During 1970s, Ethiopia is not a big fan of family planning due to Ethiopian orthodox belief. Despite these circumstances, Ethiopia government still allows family planning services to be offered in some areas with the connection of maternal and child health programs and clinics (Chang, 1974). Now, modern method contraceptive prevalence in Ethiopia had increased from 6% in 2000 to 14% in 2005 (Beekle & McCabe, 2006).

Distributions of contraceptives method differs among countries. In France, Germany, Italy, Spain, and the United Kingdom, 30% of women of childbearing age prefer oral contraceptive; 20% relied on the partner's use of a condom; 11% used a reversible long-term contraception; 11% either partner was sterilized; and another 6% relied on "traditional methods" (Benagiano, Bastianellil, & Farris, 2006). Regardless of the variety selection of methods available today, the four most popular are female sterilization, Oral Contraceptives, injectables, and intrauterine devices (IUDs); account for almost three-quarters of all contraceptives used.

In Malaysia, oral contraceptives are still the utmost popular method, although the percentage of its usage had drop from 1974 (50.2%) to 2004 (27%). After oral

contraceptives, 17.9% of Malaysia population prefer rhythm method, 14.5% prefer the use of condom and 12.5% op for either partner sterilization (Wang, 1989).

2.2 Family Planning

The factors that influence contraceptive awareness and practice are multifaceted and challenging (Beekle & McCabe, 2007). The changes in attitudes towards the use of contraceptives are important indicators of potential changes in practice of family planning. It is thereby apparent that the strength of motivation to curtail childbearing should have a positive effect on the intention to use contraceptives; that knowledge is a matter of familiarity with contraception and also should have a positive effect on the intentional to use a method; that social acceptability concerns approval of contraception and therefore should have a positive effect on the intentional use; that the wife's perception of the husband's attitudes captures aspects of the husband's view that should facilitate contraceptives use; that the health-concerns indicator is a positive function of fears about detrimental side effects of contraceptive; and hence should have a negative effect on the intention to use (Casterline, Sathar, & ul Haque, 2001).

2.2.1 Attitudes and Practices

Woman's decision to practice contraception is mainly influences by her husband, her health, religion and social customs (Van Keep & Rice-Wray, 1973; Casterline, Sathar, & ul Haque, 2001). Beekle and McCabe (2006) also noted that the most commonly cited reasons for not using modern contraceptives were the desire for more children, fear of side effects, opposition from partner and religious beliefs. Men are seen as the main decision-makers in the family. Family members, particularly husbands, play a critical role in women's family planning use and continuation. Plummer et al. (2007) correspond that the dynamics of gender and power are likely to have contributed to this situation. Casterline Sathar, and ul Haque, (2001) states that a woman is unlikely to use a method without her husband

approval. Furthermore, some women's fear of divorce leads them to continue childbearing even if they want no more children (Petro-Nustas, 1999). For that reason, wives' perception that their husbands are opposed to or not supportive of family planning are a key obstacle to family planning and is a dominant factor discouraging contraceptives practice (Casterline, Sathar, & ul Haque,, 2001).

According to Oni and McCarthy (1991), differences in the relative authority and the responsibility of men and women also revealed that men feel that they should have a major role in the decision to limit fertility but that the responsibility for the actual use of contraceptives lies predominantly with women. Some researchers also found out that men are somewhat more willing to support their wives in using contraceptives than they are to consider using them themselves. Plummer et al. (2006) in their study state that majority of men uses the excuses that using male contraceptives will cause unpleasureable experience for them. On the contrary, some researchers found out that most men acknowledge the man's responsibility in planning pregnancies and indicate a willingness to use male contraceptives (Oni & McCarthy, 1991). When both attitudes and high social support are favourable, even with low accessibility, an overwhelming majority use family planning (Kar, 1978).

2.2.2 Spousal Communications

Spousal communication, too, is an important predictor of contraceptive use and must be considered in family planning service delivery (Odimegwu, 1999). Other researches acknowledge that contraceptives use is dramatically higher among couples who discussed family planning with each other. Van Keep and Rice-Wray (1973) in their study concluded that over three quarters of the respondents felt that it is not for the husband alone to decide whether contraception should be practiced. Oni and McCarthy (1993) in their research recognized that couples who do discuss family planning find, to their surprise, that both of them support the use of contraceptives but that neither was aware of the other's positive view. A study by Beekle and McCabe (2006) showed that current contraceptive practice was found to

be strongly associated with spousal discussion about family planning. According to them, there was also an association between husband approval of current contraceptive practice and spousal discussion. Literate women were more likely to discuss family planning with their husbands. Women's educational status and occupation had a positive association with spousal discussion about the preferred number of children (Beekle & McCabe, 2006). Nigerian's increased contraceptive use may be attributable to their changed perceptions of family planning brought about both by the government's information, education and communication campaign (Odimegwu, 1999).

2.3 Instrumentation

The questionnaire from the nationwide campaigns of family planning conducted in Nigeria by the Family Health Services Project (FHS) Information, Education and Communication (IEC) Division was utilized with some modification in this study. All of the attitudinal components are utilized without any modification. The demographic data and there is also a modification in the question regarding practice of family planning. The original questionnaire was modified to suit the objectives of this study.

2.4 Conceptual Framework

The Theory of Planned Behaviour (TPB), proposed by Icek Ajzen in 1985 is use to explain the attitude and practice of family planning among men and women. TPB is an excellent model to explain health-related decision making as it specifies the nature of the relations between beliefs, attitudes and behaviour (Ajzen, 1991).

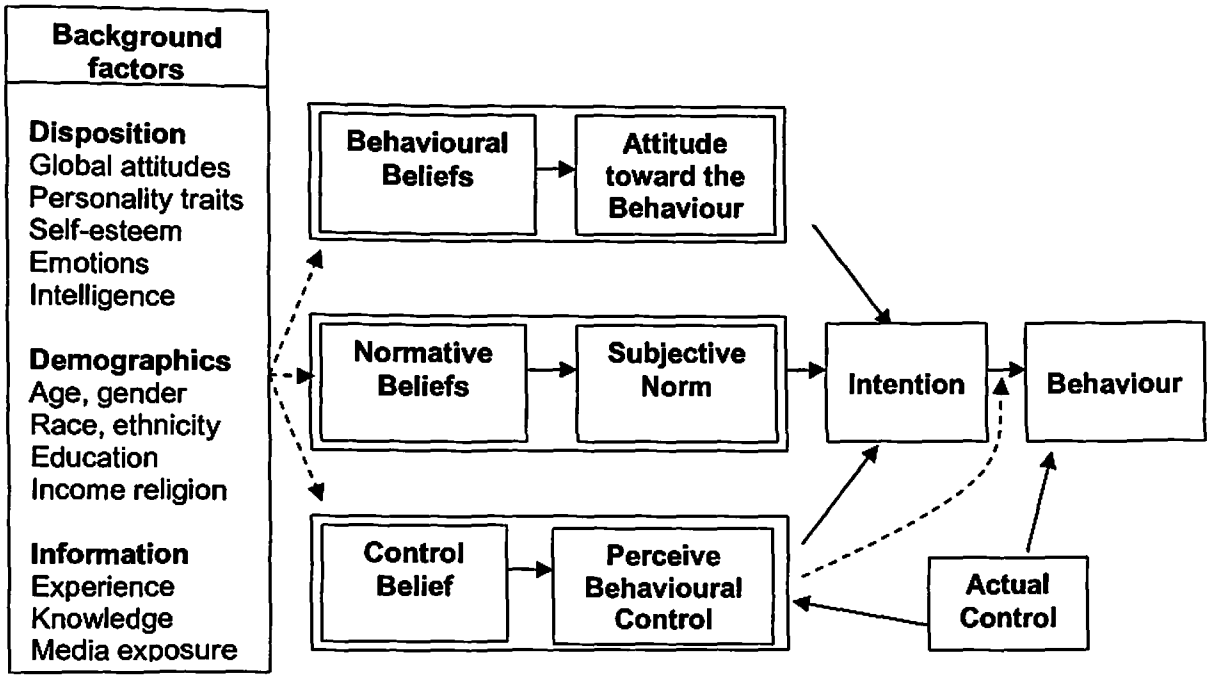


FIGURE 2.4 Schematic representation of the Theory of Planned Behaviour

According to TPB, human behavior is guided by three kinds of considerations: behavioral beliefs, normative beliefs, and control beliefs.

1. Behavioural Beliefs and Attitude toward the Behavior
   i. Behavioural Beliefs is an individual's beliefs about the likely outcomes of the behavior.
   ii. Attitude toward the Behavior is the individual's evaluations of his self-performance outcomes. The evaluations can be either positive or negative.

2. Normative Beliefs and Subjective Norm
   i. Normative Beliefs is an individual's expectation of the particular behaviour.
   ii. Subjective Norm is the individual's motivation to obey with these expectations. That individual's motivations can be influenced by social normative pressure; whether they are expected by their friends, family and the society to perform the recommended behavior.

3. Control Beliefs and Perceived Behavioral Control
    i. Control Beliefs is an individual's beliefs about the presence of factors that may facilitate or impede performance of the behavior.
    ii. Perceived Behavioral Control is the individual's perceived power of these factors; the perceived ease or difficulty of performing the particular behavior.

4. Behavioral Intention and Behavior
    i. Behavioral Intention is an indication of an individual's readiness to perform a given behavior.
    ii. Behavior is the stage where an individual's response in a given situation with respect to a given target.

(Ajzen, 1991)

In their respective aggregates, behavioral beliefs produce a favorable or unfavorable attitude toward the behavior; normative beliefs result in perceived social pressure or subjective norm; and control beliefs give rise to perceived behavioral control. In combination, attitude toward the behavior, subjective norm, and perception of behavioral control lead to the formation of a behavioral intention. As a general rule, the more favorable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person's intention to perform the behavior in question. Finally, given a sufficient degree of actual control over the behavior, people are expected to carry out their intentions when the opportunity arises. Intention is thus assumed to be the immediate precursor of behavior.

(Ajzen, 1991)

CHAPTER 3

METHODOLOGY

3.1 Research Design

This research is a cross-sectional, descriptive study using self-administered questionnaire.

3.2 Population and Setting

This study was conducted in the Obstetric and Gynecology Clinic, HUSM. The clients in the clinic are divided into antenatal, postnatal and gynecological categories. Only the postnatal clients were selected in this study.

3.3 Sample

3.3.1 Sample Size

Based on the Obstetric and Gynecology Clinic's registration book, from January to June 2008, there were 524 postnatal cases. By average, there are 87 postnatal women per month. Data collection will be done in two months, so the average population pf postnatal women in Obstetric and Gynecology Clinic is 174. In order to determine the sample size, the Krejcie and Morgan's (1970) Sample Size Table is used. The Sample Size table is available in Chua (2006), page 186. Based on the table, the sample size is 118. Together with 10% drop out, the sample size in this study is 130. But after data collection, only 65 respondents obtained for this study.

Table 3.1.1: Krejcie and Morgan (1970) Sample Size determination

Population	Sample
130	97
140	103
150	108
160	113
*** 170**	**118**
180	123
190	127
200	132

3.3.2 Sampling Design

A purposive sampling method was employed to select the participants for the study. Confidentiality was assured to all participants.

3.3.3 Inclusion and exclusion criteria

The following are the inclusion criteria for the selection of study participants:

i. Postnatal women
ii. Married
iii. Attended Obstetric and Gynecology clinic in HUSM
iv. Men that accompany their wife
v. Able to speak and understand Bahasa Malaysia

The following are the exclusion criteria for selection of study participants:

i. Divorce
ii. Antenatal women
iii. Women attending Obstetric and Gynecology Clinic for gynecology purposes
iv. Unable to speak and understand Bahasa Malaysia

3.4 Instrumentation

3.4.1 Instrument

Self-administer questionnaire was utilized in this study. The questionnaire consists of three sections; Section A, B and C and will take 10 to 15 minutes to complete. Section A consists of respondent's sociodemographic characteristics:

i. age

ii. sex

iii. education level

iv. occupation

v. numbers of living children

vi. numbers of desired children

Section B consists of 26 attitudinal statements under these 6 subtopics:

i. family well-being and family planning

ii. health benefits of family planning

iii. female education and early marriage

iv. marital relations

v. societal values

vi. men's role in family planning.

Section C consists of one question regarding:

i. practice of contraceptives

3.4.2 Variables Measurement

i. Independent variables (X):

- Attitude towards family planning
- Education level
- Number of desired children

ii. Dependent Variables (Y):

- Practice of family planning

Data from section A, B and C of the questionnaire was measured and presented in percentage. In section B, respondents were asked to rate their level of agreement by using a 5-point Likert-type scale from one (strongly agree) to five (strongly disagree). A 53-point attitude score will be use to summarize each respondent's attitudes toward family planning. One point was awarded for each response supportive of family planning; one point was deducted for each response indicating opposition; each neutral response earned no points. The scale ranged from -26 points (most opposed) to +26 points (most supportive) (Kiragu, Krenn, Kusemiju, Ajiboye, Chidi, & Kalu, 1996). Respondents were then classified into two groups: opposed (-26 to 0 points), and favorable (1 to +26 points).

3.4.3 Validity

The questionnaire was validated by the researcher from previous study. The questionnaire was utilized in the nationwide campaigns of family planning conducted in Nigeria by the Family Health Services Project (FHS) Information, Education and Communication (IEC) Division between the year of 1988 and 1993 (Kiragu et al., 1996).

3.4.4 Translation of Instrument

The questionnaire is in English and was translated into Bahasa Malaysia for the convenience of the respondents. The translation process occurs in three phases: self-translation, re-checking by supervisor and university's language centre.

3.4.5 Reliability

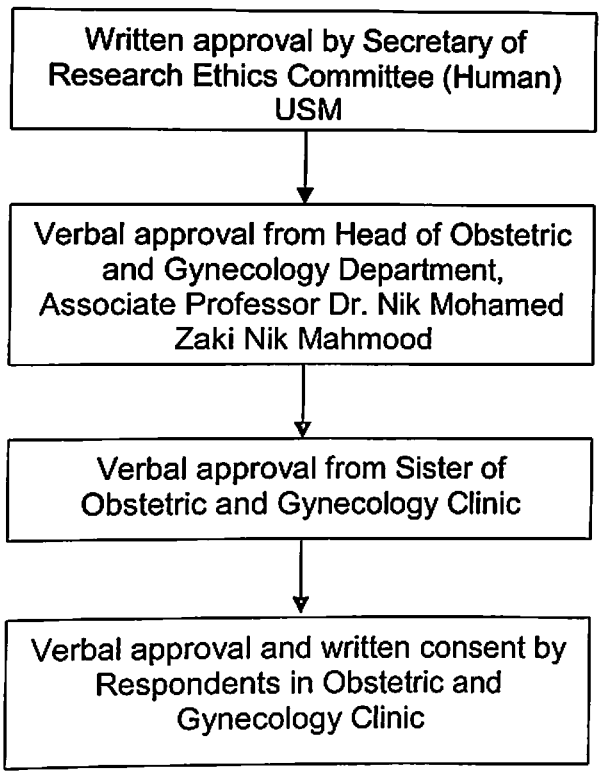
A pretest of the questionnaire was conducted with five men and five women who met the inclusion criteria and attended the Obstetric and Gynecology Clinic, HUSM. The purpose of the pilot was to test the clarity and relevance of the questionnaire and to familiarize the data collectors with the instrument. The responses from the pilot study were checked for completeness and consistency. The findings from the pilot study did not show potential problems; with Cronbach's Alpha

for internal consistency is 0.88. In order to avoid response biases, the participants in the pilot study were not included in the main survey.

3.5 Ethical Consideration

The research proposal was reviewed and approved by the Research Ethics Committee (Human) USM, Clinical Science Research Platform. After that, verbal approval was obtainend from Obstetric and Gynecology Head of Department. Informed consent was obtained from each participant prior to the interview. Moreover, participants were informed regarding the study, verbally and in writing. All participants' right to autonomy will be respected and confidentiality was maintained throughout the research process. Ethical considerations that were taken into account throughout this study are beneficence and non-maleficence; autonomy; justice; rights and dignity.

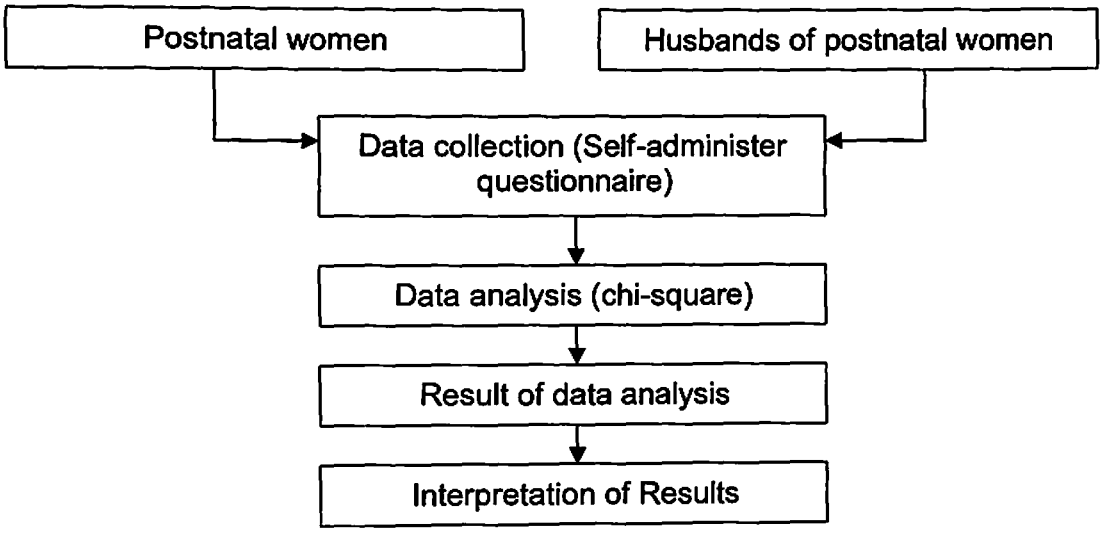
3.5.1 Flow Chart of Ethical Consideration



3.6 Data Collection Method

After ethical approval, data was collected with the aid of questionnaire within a month; throughout February 2009. Clients who agreed to participate were asked to fill out a consent form and the three sections questionnaire. The interviews were conducted in Bahasa Malaysia as it is the everyday language of Malaysian.

3.6.1 Flow Chart of Data Collection



3.7 Data Analysis

Throughout the data analysis, the Statistical Package for Social Science (SPSS) version 12 software was used to assist with organization, management and analysis of the data. The study used Chi-square to determine if there is a statistically significant association between variables. Comparison and association are considered statistically significant when *p-value* is less than 0.05 (α=0.05) and thus null hypothesis rejected.

CHAPTER 4

RESULTS

4.1 Sociodemographic Data

A total of 67 men and women in Obstetric and Gynecology Clinic were invited and agreed to take part in the study. One questionnaire was rejected due to respondent's drop out due to unable to complete the questionnaire. Another one questionnaire was rejected because it was filled twice by a same respondent, leaving only 65 questionnaires available for analysis.

Table 4.1 summarized the sociodemographic data of the respondents. The youngest respondent aged 19 while the oldest was 49 years old with majority of them stands in age group less than 30 years old (f=35).

Education level is divided into two groups; secondary education and below, and tertiary education and above. Secondary education and below group consists of respondents with no schooling, primary and secondary education level. While tertiary education and above group consist of respondents with diploma, degree and higher. Most of the respondents in this study comes from secondary and below group (f=46), where 20 of them are male and 26 are female.

More than half of the female respondents are housewife (f=22), while half of the male respondents are self-employed (f=14). The remaining 44.6% of the respondents' work either in government (29.2%) and private sector (19.4%).

60 of the respondents have 4 children or less (92.3%). Among these 60 respondents, 37 of them wanted 5 or more children. From the study, men seem to desire for more than 5 children with the increased percentage from 4% to 36% compared to women with the increase of 25.6%.

Table 4.1: Frequency of Sociodemographic Data (n=65)

Characteristics	Total (n=65) *f* (%)	Men (n=25) *f* (%)	Women (n=40) *f* (%)
Age			
30 years and below	35 (53.8)	12 (48.0)	23 (57.5)
31 years and above	30 (46.2)	13 (52.0)	17 (42.5)
Education			
Secondary education and below	46 (70.8)	20 (80.0)	26 (65.0)
Tertiary education and above	19 (29.2)	5 (20.0)	14 (36.0)
Occupation			
Unemployed/ Housewife	22 (33.8)	-	22 (55.0)
Government sector	19 (29.2)	8 (32.0)	11 (27.5)
Private sector	10 (15.4)	4 (16.0)	6 (15.0)
Self-employed	14 (21.5)	13 (52.0)	1 (2.5)
Number of Living Children			
4 and below	60 (92.3)	24 (96.0)	36 (90.0)
5 and more	5 (7.7)	1 (4.0)	4 (10.0)
Number of Desired Children			
4 and below	42 (64.6)	16 (64.0)	26 (65.5)
5 and more	23 (35.4)	9 (36.0)	14 (35.6)

4.2 Attitudes of Men and Women towards Family Planning

Respondents are generally supportive of family planning, although women are more likely than men to agree on the positive attitudinal statements. 23 out of 26 of the attitudinal statements showed positive attitudes towards family planning (Table 4.3). The highest agreed upon statement is child spacing protects the health of mothers (95.4%). When asked whether family planning can help a couple to become

responsible parents, 95% of women agreed with the statement compared to only 88.0% of men. Majority of the men and women agreed that men should share the responsibility for family planning (92.3%).

Almost equal proportion of both men (76.0%) and women (75.0%) agreed that it is not embarrassing to talk about family planning with their spouse in marital relations. Female respondents (42.5%) were more likely than males (16.0%) to agree that having large family strains a couple relationships. The least famous statement is the statement early marriage and childbearing can damage a girl's health with only 20 respondents; 6 men and 14 women, agreed on the statement. Approximately 57% of total respondents disagreed with that women who used family planning looks younger; only 11 male and 17 female respondents agreed with it.

Table 4.2: Frequency and Percentage of Positive Attitudinal Statements towards Family Planning (n=65)

Attitudinal Statement	**Total (n=65) f (%)**	**Men (n=25) f (%)**	**Women (n=40) f (%)**
Family well-being and family planning			
Family planning can help a couple to become responsible parents	60 (92.3%)	22 (88.0%)	38 (95.0%)
Family planning will help improve one's standard of living	53 (81.5%)	20 (80.0%)	33 (82.5%)
Health benefits of family planning			
Child spacing protects the health of mothers	62 (95.4%)	22 (88.0%)	40 (100.0%)
Women who use family planning look younger	28 (43.0%)	11 (44.0%)	17 (42.5%)
Female education and early marriage			
You should let your daughter finish school before she marries	58 (89.3%)	22 (88.0%)	36 (90.0%)
Early marriage and childbearing can damage a girl's health	20 (30.8%)	6 (24 .0%)	14 (35.0%)

Table 4.2: Frequency and percentage of Positive Attitudinal Statements towards Family Planning (n=65) (continued)

Attitudinal Statement	Total (n=65) f (%)	Men (n=25) f (%)	Women (n=40) f (%)
Marital relations			
Spouses who care for each other will practice family planning	56 (86.2%)	20 (80.0%)	36 (90.0%)
Having a large family strains a couple's relationship	25 (38.4%)	4 (16.0%)	17 (42.5%)
It is embarrassing for me to talk to my spouse about family planning	49 (75.4%)	19 (76.0%)	30 (75.0%)
Societal values			
Practicing family planning will create a better society	53 (81.5%)	18 (72.0%)	35 (87.5)
Men's role in family planning			
Men should share the responsibility for family planning	60 (92.3%)	22 (88.0%)	38 (95.0%)

4.3 Family Planning Practice

In third part of the questionnaire, respondents were asked whether they ever practiced family planning by using various methods of contraceptives. Only 43.8% (*f*=22) of the respondents ever practiced family planning (Table 4.3). Among them, only 8 men and 14 women ever practiced family planning. More than half of the respondents (56.2%) never applied any family planning.

Table 4.3: Frequency and percentage of Family Planning Practice (n=65)

Family Planning Practice	Total (n=65) *f* (%)	Men (n=25) *f* (%)	Women (n=40) *f* (%)
Yes	22 (43.8%)	8 (32.0%)	14 (35.0%)
No	43 (56.2%)	17 (68.0%)	26 (65.0%)