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Identifying Attitudes of Married Women Between the Ages of 15 and 49 Living in Elazig Province of Turkey Towards Reproductive Health

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Introduction: Reproductive health affairs have traditionally been associated with fertility; therefore, the focus has been on women, which has a more important role to play in this function. This study was carried out to identify the attitudes of married women towards reproductive health.

Materials and Methods: The population was comprised of all 15 to 49-year-old married women registered for the Number 63 Family Practice Center, which was located in Elazig, Turkey. The study was completed with 246 participants who agreed to participate. The data analysis involved mean scores, standard deviation values, numbers and percentages, an independent sample t-test, ANOVA, and Tukey's Honest Significant Difference (HSD).

Results: The mean age of the participants was 34.06±7.9 years. The mean score of the participants in the SIRH was 143.49±16.28. Whereas the sub-scale with the highest mean score was seeing a doctor for problems associated with reproductive health (34.92±5.95), the one with the lowest mean score was protection against reproductive cancers and breast cancer (7.19±4.19).

Conclusion: The participants had an intermediate mean score in the overall SIRH. To improve their reproductive health, women should be enabled to benefit from primary training opportunities and trained by health care professionals in how to maintain their reproductive health. It is also recommended that reproductive health services should be popularized.

Keywords: Reproductive, women, family, planning, abortion

Introduction

Reproductive health affairs have traditionally been associated with fertility; therefore, the focus has been on women, which has a more important role to play in this crucial function. Accordingly, maternal and child health has been attached to more importance.

The perspective underwent a change in the years that followed the 1990s. The notion of reproductive health was first mentioned in the International Conference on Population and Development, with worldwide acceptance. In the conference, states should take all relevant actions, based on the equality of women and

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men, to make sure that all health care services, including reproductive health services such as family planning and sexual health, should be made universally accessible (1).

The proceedings of the conference were also emphasized in the Fourth World Conference on Women, which was held in Beijing in 1995, and they were incorporated into the action plan. The action plan was mainly focused on the empowerment of women, relationship between development and population, the achievement of gender equality and justice, prevention of violence against women, reproductive health and family planning, and girls, young people and the elderly. The action plan stressed that family planning should be incorporated into reproductive health, a broader concept. It was stipulated that reproductive health services should be accessible to the appropriate age through basic health care services (1-3).

The World Health Organization (WHO) describes reproductive health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity concerning the reproductive process and functions." Reproductive health refers to a state in which individuals enjoy a happy and safe sexual life, they retain their ability to reproduce, and they are free to decide whether, when and how frequently they will use this ability of theirs. The term also involves older approaches and concepts such as women reproduction, fertility, maternal and child care, and family planning; furthermore, it is the reflection of the understanding that assigns equal roles to women and men in reproduction and the assessment of its consequences (3-6).

According to the WHO, the objective of reproductive health programs is to make sure that individuals can enhance their capacity for healthy, equal, and responsible relationships and sexual life as well as healthy sexual growth and maturity and to ensure that they can implement decisions regarding reproduction safely and healthily. One more objective is to ensure that individuals can protect themselves against disease and infirmity associated with sexuality and reproduction and that they can have access to guidance when necessary (2,3).

Nevertheless, many women around the world are unable to access reproductive health services owing to such reasons as insufficient knowledge about sexuality and health, lack of background education in this respect, inappropriate or insufficient reproductive health services, discriminatory social practices, discrimination against girls and women, and violence against women. This is the fact that reproductive health is of special or even vital importance to women (7). The maintenance of women's reproductive health is essential for healthy and happy families and, therefore a healthy future. Besides, a risk threatening the woman's reproductive system will not be limited to that woman; instead, it will have an adverse impact on the next generations as well (8). The risks confronting women about their reproductive health are also increased because subjects concerning reproductive health cannot be talked about with others in a comfortable way and that they have incomplete or wrong knowledge about them (9).

This study was carried out to identify the attitudes of married women in the city center of Elazig, Turkey, towards reproductive health.

Materials and Methods

This descriptive, cross-sectional study was conducted in the province of Elazig, which is located in the southwestern part of the Eastern

Anatolia Region of Turkey. Yıldız baglari neighborhood, located in the city center, was preferred in terms of ease of implementation and its low socioeconomic level. The study population consisted of married women aged 15-49 years who were registered to the family medicine clinic in this area. After obtaining the necessary institution permissions to conduct the research, the study was completed with 246 participants who agreed to participate and admitted to the family medicine clinic between October 2011 and March 2012. The data were collected by the researchers using the face-to-face interview method. There were two data collection instruments. The first one was the Personal Information Form, designed by the researchers about the literature and contained questions as to demographics and obstetrics. The second one was the Scale for Identification of the Attitudes of Married Women to the Maintenance of Reproductive Health (SIRH), composed by Demirci (2004), who also tested its validity and reliability.

The scale had 39 items measured with a five-point Likert-type scale (never, rarely, sometimes, usually, and always). The items were loaded under five sub-scales, namely seeing a physcian for problems associated with reproductive health, protection against cancers and breast cancer, general behaviors of

Table-1. The distribution of the participants by their obstetrics

Variables	Options	Number	Percentage
Length of marriage	*5 years and shorter*	58	23.6
	6-10 years	44	17.9
	11 years and longer	144	58.5
Gestational age	*18 years and younger*	40	16.3
	18-24 years	156	63.4
	25 years and older	50	20.3
Number of live births	*None*	25	10.2
	1-3 births	197	80.1
	4 and more	24	9.8
Interval between two cases of pregnancy	*Shorter than two years*	48	24.5
	2 years and longer	148	75.5
Contraception	*Yes*	178	72.4
	No	68	27.6
Adopted method of family planning	*Condom*	61	33.7
	IUDs	39	21.5
	Oral contraceptive	36	19.9
	Withdrawal	29	16.0
	Injection	10	5.5
	Tubal ligation	6	3.3
Being informed about the adopted method	*Yes*	137	74.9
	No	46	25.1
Source of Information	*Nurse/ Midwife*	118	86.0
	Doctor	16	11.8
	Neighbor/relative	3	2.2

the maintenance of reproductive health, protection against genital tract infections, and protection against unwanted pregnancy. Whereas the lowest possible score on the scale was 39, the highest one was 195. Higher scores in the subscales and the overall scale represented more positive behaviors of and attitudes to the maintenance of reproductive health. Before the administration, an informed consent was granted and approved by the Provincial Directorate for Health in Elazığ and the Academic Ethics Committee of Firat University. The data analysis involved numbers, percentages, mean scores, an independent samples t-test, ANOVA, Tukey's HSD, the Mann-Whitney U test, and the Kruskal Wallis analysis of variance.

Results

The mean age of the participants was 34.06±7.9 years. The great majority of them were housewives (91.9%), and 38.2% of them were primary school graduates. More than two-thirds of them (71.5%) described their economic status as intermediate (Table-2). Whereas the mean age of marriage was 20.45±3.61 years, the mean gestational age was 21.60±3.74 years.

Table-2. The mean scores of the participants in the sub-scales of the SIRH

Sub-scales	Mean±SD	Min-Max
Seeing a doctor for problems associated with reproductive health	34.9±5.95	11-40
Protection against reproductive cancers and breast cancer	7.19±4.19	4-20
General behaviors of maintenance of reproductive health	28.2±5.49	14-45
Protection against genital tract infections	60.9±6.16	40-75
Protection against unwanted pregnancy	12.2±3.27	3-15
Total	143.4±16.2	102-188

Table-1 shows the distribution of obstetric characteristics of women. Of the participants, 58.5% was married for 11 years or longer. The first pregnancy of 63.4% had between the ages of 18 and 24. Of the women, 80.1% had 1 to 3 live births. Of the participants, 75.5% stated that there were at least two years between the two pregnancies, 72.4% was using contraceptive measures, 84.0% was using one of effective family planning methods, 74.9% was informed about the family planning method used, and 86.0% obtained this information from nurses or midwives.

Table-2 presents the distribution of the participants by their mean scores in the SIRH and its sub-scales. The mean total score of women participating in the study was found to be 143.49±16.28 (minimum 102-maximum 188). The distribution of the mean SIRH sub-scale scores of the women included in the study according to some characteristics is shown in Table-3. Their mean scores in seeing a doctor for problems associated with reproductive health differed significantly depending on perceptions of economic status ($p<0.05$). The discrepancy was in favor of those who perceived their economic status as high, and the mean score of that group was higher than those of others ($p<0.05$). Nevertheless, no significant difference existed among the groups in terms of the other variables.

The mean scores in protection against reproductive cancers and breast cancer differed significantly depending on occupational status and age ($p<0.05$). Those participants who were 25 years old or younger had a mean score of 5.05±2.09, which was lower than those of the other groups ($p<0.05$). The working participants got a higher mean score when compared to the non-working ($p<0.05$) (Table-3).

The mean scores in general behaviors of maintenance of reproductive health differed depending on occupational status, educational status, age, and perceptions of economic status ($p<0.05$). Those participants who were 25 years old or younger, who were high school or university graduates and who perceived their economic status as high, had higher mean scores in the sub-scale, and the discrepancy was significant ($p<0.05$) (Table-3).

The mean scores in the protection against genital tract infections differed depending on educational status, occupational status, and perceptions of economic status ($p<0.05$). Those participants who were high school or university graduates, who worked and who perceived their economic status as high had better mean scores in the sub-scale ($p<0.05$). However, age did not lead to a difference in terms of the mean scores in the sub-scale ($p>0.05$)(Table-3).

Table-3. The distribution of the mean scores of the participants in the sub-scales of the SIRH by certain demographics

Variables	Seeing a doctor for problems associated with reproductive health	Protection against reproductive cancers and breast cancer	General behaviors of maintenance of reproductive health	Protection against genital tract infections	Protection against unwanted pregnancy
Age	*Mean ±SD*	*Mean ±SD*	*Mean ±SD*	*Mean ±SD*	*Mean ±SD*
▪ *25 years or younger*	35.30±5.22	5.05±2.09*	30.50±6.22*	61.58±4.54	12.35±2.72
▪ *26-35 years old*	34.92±6.11	7.16±3.94	28.40±4.93	61.56±5.89	12.56±3.12
▪ *36 years and older*	34.77±6.10	8.03±4.73	27.29±5.51	60.05±6.86	11.80±3.58
p-value	*0.945*	***0.0001***	***0.006***	*0.16*	*0.413*
Educational Status					
▪ *Literate/Illiterate*	34.50±5.86	6.83±3.44	25.28±5.36	57.25±6.55	11.61±3.64
▪ *Primary school or secondary school*	34.56±6.34	6.90±4.03	27.68±4.78	60.42±6.13	11.95±3.40
▪ *High school or university*	35.70±5.29	7.82±4.72	30.59±5.81*	63.42±4.93*	12.89±2.77
p-value	*0.451*	*0.270*	***0.0001***	***0.0001***	*0.086*
Occupational Status					
▪ *Working*	34.55±7.10	9.00±4.95	32.65±6.71	65.80±4.11	13.35±1.98
▪ *Non-working*	34.95±5.86	7.03±4.09	27.88±5.22	60.49±6.13	12.10±3.35
p-value	*0.863*	***0.04***	***0.0001***	***0.0001***	*0.153*
Economic status					
▪ *High*	37.10±4.27*	8.00±4.38	30.02±7.01*	62.88±5.93*	12.35±3.15
▪ *Average*	34.69±5.95	7.18±4.27	27.87±5.07	60.57±6.01	12.34±3.28
▪ *Low*	32.00±7.55	5.50±4.19	27.59±4.34	59.45±7.14	10.77±3.28
p-value	***0.002***	*0.068*	***0.046***	***0.035***	*0.099*

The mean score in protection of unwanted pregnancy did not differ depending on age, educational status, occupational status, or perceptions of economic status (Table-3).

The distribution of the mean SIRH sub-scale scores according to the information sources and family planning methods used by women are shown in Table-4. Those participants that used an effective method of family planning had higher mean scores in protection against genital tract infections and protection against unwanted pregnancy ($p<0.05$). Besides, those who reported being informed about the adopted method of family planning got higher mean scores in protection against reproductive cancers and breast cancer, protection against genital tract infections, and protection against unwanted pregnancy ($p<0.05$). Furthermore, those participants whose source of information was health care professionals had a higher mean score in seeing a doctor for problems associated with reproductive health, protection against genital tract infections, and protection against unwanted pregnancy ($p<0.05$)(Table-4).

Finally, a higher mean score was achieved in the overall SIRH by those participants who were high school or university graduates, who worked, who perceived their economic status as high, who used an effective method of family planning, who were informed about the adopted method of family planning, and whose source of information was health care professionals ($p<0.05$).

Discussion

The mean age of the participants was 34.06±7.9 years. Similarly, the mean ages of the participants- married women- were 34.4± 5.6 years (10). Moreover, 32.21±9.01 years (11) in two other studies conducted in Samsun and Kayseri, respectively. A review of foreign

Table-4. Distribution of the mean SIRH sub-scale scores according to the information sources and family planning methods used by the women

Variables	Seeing a doctor for problems associated with reproductive health	Protection against reproductive cancers and breast cancer	General behaviors of maintenance of reproductive health	Protection against genital tract infections	Protection against unwanted pregnancy
Adopted method of FP	*Mean ±SD*	*Mean ±SD*	*Mean ±SD*	*Mean ±SD*	*Mean ±SD*
▪ Effective	35.47±5.59	7.41±4.29	28.49±5.35	61.92±5.74	13.2±2.2
▪ Ineffective	33.14±6.89	6.1±3.58	27.17±5.39	58.03±5.45	7.03±3.83
p-value	*0.137*	*0.087*	*0.227*	***0.001***	***0.0001***
Being informed					
▪ Yes	35.63±5.36	7.5±4.29	28.49±5.02	62.26±5.42	13.3±2.23
▪ No	33.41±7.05	6.15±3.72	27.39±6.28	57.98±6.30	8.74±4.02
p-value	*0.091*	***0.017***	*0.231*	***0.0001***	***0.0001***
Source of information					
▪ Doctor/nurse/midwife	35.89±5.16	7.58±4.33	28.46±5.07	62.38±5.36	13.47±1.99
▪ Neighbor/relative	25±4.36	4.33±0.58	27.67±0.58	55±2.65	6.67±2.52
p-value	***0.007***	*0.168*	*0.788*	***0.019***	***0.0001***

studies, on the other hand, suggested that the mean ages of married women were 29.49, 32 and 38.09±7.43 years in Ethiopia, India and China respectively (12-14).

The participants of the present study were mostly (38.2%) primary school graduates. A study reported a similar finding carried out in Bingol (Turkey), in which 37% of the women participants were primary school graduates (15). Nevertheless, two studies conducted in two other cities of Turkey, namely Sivas and Tokat, reported that 55.6% and 64.3% of the women participants were primary school graduates (16,17). A review of foreign studies suggested that married women in Ethiopia and India were primary school graduates by 32.9% and 15.3% respectively (12,18).

The age of marriage is accepted as significant demographic indicator since it suggests that the woman is at risk of pregnancy. In the present study, the mean age of marriage for the participants was 20.45 years. Likewise, Egri and Golbasi reported that the mean age of marriage for the participants in their study was 18.7 years, and the mean age of marriage for the participants in another study by Sevindik et al. was 19.5 years (17,19). Similarly, the mean age of marriage for the women participants was 20.71 years in a study carried out by Erbil (20). According to the results of the 2008 Turkey Health and Population Study, the median age of marriage in Turkey was 20.8 years. Furthermore, it was reported that the mean age of marriage for the women participants in a Chinese study was 21.99±1.85 years (14).

The safest age range for pregnancy and delivery is when women are 20 to 29 years old. In the present study, the mean gestational age of the participants was 21.60±3.74 years. The mean gestational ages of women in Aydin and Nigde, two cities of Turkey, were reported to be 22.69±3.72 and 19.7±0.18, respectively (21,22).

First pregnancy and delivery, as well as fourth and more deliveries, are acknowledged to put women at risk of maternal death. In the present study, the mean number of pregnancies that the participants had was 2.61±1.58, whereas the mean number of live births was 1.92±1.14. In another study conducted by Kaya et al., the number of pregnancies was 2.73±1.61 among the participants whereas the number of live births was 2.56±1.48 (10). Also, Dundar et al. reported that the number of deliveries and the number of live births among the participants in a study were 2.1±0.9 and 1.8±0.7 respectively (15). According to the results of the 2008 Turkey Population and Health Study, the fertility rate among Turkish women was 1.70 (23). Nevertheless, the fertility rate among Turkish women was reported to be 2.1 by the 2012 Turkish Health Statistics Yearbook (24). The rate in the present study was quite close to the average across Turkey.

Unwanted pregnancy might pose a threat to women in different ways, the most important of which is to attempt to terminate an unwanted pregnancy through miscarriage. Such attempts, especially those in unsafe environments and by the woman herself, are the primary reason for maternal death. According to the data published by the World Health Organization in 2008, unsafe miscarriage accounted for 13% of maternal deaths and 5 million women were hospitalized every year due to complications associated with unsafe miscarriage (25). In the present study, the number of miscarriage that the participants had was 1.39+0.72. According to the results of the 2008 Turkey Population and Health Study, nevertheless, the number of miscarriage and miscarriage rates was 0.3 and

0.29 respectively among women aged 15 to 49 years old (23). In the present study, 26.8% of the participants had a miscarriage experience. In a foreign study, the prevalence among Chinese women was reported to be 32% (14).

In the present study, the mean number of children that the participants wanted to deliver was 2.51±1. Similarly, a study conducted in Iran reported that the number of children that the participants wanted to have was 2.4±1.3 (26). In the present study, the participants had one child, two children, and three children by 25.2%, 38.2% and 16.7% respectively. However, a Chinese study reported prevalence among Chinese women for each category to be 36.8%, 51.2%, and 10.7% respectively (14).

The present study revealed that 73.6% of the participants adopted contraceptive methods. The top three modern contraceptive methods were condoms (33.7%), IUDs (21.5%), and oral contraceptives (19.9%). Similarly, the results of the 2008 Turkey Population and Health Study indicated that the prevalence of contraceptive methods among Turkish women was 73%, and the most common modern methods were IUDs and condoms. As for traditional methods, the most common one was withdrawal (23). That finding of the present study is supported by those of Kaya et al. and Giray et al. (15,27).

According to another clinical study, 80% of Norwegian women use a contemporary contraceptive method and the most common ones are COCs (56%) and condoms (20%) (28). In Ethiopia, however, the prevalence of modern contraceptive methods among married women is 46.9%, and the most common method of family planning is injected contraceptives (62.9%), which is followed by IUDs (14%) and COCs (12). According to an Iranian study, many married women there (28.4%) use natural methods of family planning. Out of the modern methods, the most common ones are oral contraceptives (26.8%), condoms (25.5%), and IUDs (10.1%). In Malaysia, the prevalence of modern methods of family planning among married women is 30% (29), whereas 93.9% of Chinese women use contraceptive methods. The most common modern method in the latter is surgical sterilization (53.1%), which is followed by IUDs (35.4%) and condoms (8.7%) (14).

In the present study, the mean score of the participants in the overall SIRH was 143.49. The figure is higher when compared to the ones revealed by Aytac, Kayaci, et al., and Erbil and Goktaslar, which are 124.12, 127.8, and 142.8± 20.73 respectively (30-33). This suggests that the participants in the present study exhibited more positive behaviors regarding the maintenance of reproductive health.

In the present study, the sub-scale that the participants had the greatest mean score in was seeing a doctor for problems associated with reproductive health (34.92±5.95). In contrast, the one with the lowest mean score was protection against reproductive cancers and breast cancer (7.19±4.19). On the other hand, Erbil and Goktaslar reported the mean scores in these two sub-scales to be 32.75±6.25 and 8.82±4.26 respectively (33).

As for the relationship between age and the mean scores in the sub-scales of SIRH, those participants who were 25 years or younger had lower mean score in protection against reproductive cancers and breast cancer. Individuals that have acquired accurate knowledge about attitudes to and behaviors of reproductive health since their adolescence will, as conscious and healthy parents, not only have improved sexual and reproductive health but also have positive influences on the health of

new generations that they are to raise (34). Research on young people has suggested that they have insufficient knowledge and practices concerning protection against reproductive cancers and breast cancer and that they need comprehensive training and information in this respect (35-38).

In the present study, higher educational status led to higher scores in general behaviors of maintenance of reproductive health and protection against genital tract infections. According to Sukur, similarly, women tend to get involved in fewer wrong practices regarding their reproductive health as their educational status gets higher (8). Also, Er maintains that educational status significantly affects women's attitudes towards the maintenance of their reproductive health (34). In another study by Kara, the participants who were university graduates had higher scores in general behaviors of maintenance of reproductive health and protection against genital tract infections (39). These suggest that it is essential to enhance women's educational status to maintain and enhance reproductive health.

In the present study, the working participants had higher mean scores in protection against reproductive cancers, general behaviors of maintenance of reproductive health, breast cancer, and protection against genital tract infections when compared to the non-working participants. The finding implies that women's reproductive health is positively influenced by not only their higher educational status but also their working for an income-generating job. The finding is supported by another study (39).

The present study also attempted to explore the link between economic status and the sub-scales of the SIRH. Those participants who perceived their economic status as high got higher scores in seeing a doctor for problems associated with reproductive health, general behaviors of maintenance of reproductive health, and protection against genital tract infections. The finding suggests that economic status is a decisive factor in the extent to which women benefit from health care services and develop positive health behaviors. In the study by Kara, similarly, the participants with a better income level had a higher mean score in the overall SIRH (39).

Besides, those participants whose source of information was that health care professionals had higher mean scores in seeing a doctor for problems associated with reproductive health, protection against genital tract infections, and protection against unwanted pregnancy. The finding indicates that women put what they have learned about into practice. For the maintenance of reproductive health, it is essential to access reliable information. The risks confronting women about their reproductive health are increased because subjects concerning reproductive health cannot be talked about with others in a comfortable way and that they have incomplete or wrong knowledge about them (9). Nurses play a key role in enabling women to develop positive behaviors of reproductive health and acquiring attitudes that will maintain and heal their reproductive health. It is recommended that nurses/midwives, whether they provide primary care services or work for other health care organizations, should provide women with training and counseling as to the maintenance of reproductive health.

Conclusion

In this study, married women were found to have a good level of attitudes towards reproductive health and their attitudes toward

the maintenance of their reproductive health were significantly affected by age, educational status, occupational status, and perceptions of economic status.

In order to have improved reproductive health, women should be enabled to benefit from primary training opportunities. Women with low educational status should be trained, especially by primary care staff, in how to maintain their reproductive health, that early marriage and pregnancy should be prevented, that young people should be provided with widespread counseling regarding maintenance of reproductive health, and that training programs should be held in order to promote women to use modern methods of family planning.

Conflict of Interests

The authors have declared no conflict of interest for the present article.

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