

**FACTORS ASSOCIATED WITH EXPERIENCE OF UNINTENDED  
PREGNANCY AMONG MARRIED WOMEN OF  
REPRODUCTIVE AGE IN THE  
PROVINCE OF ILOILO**

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**by**

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**ABSTRACT**

Unintended pregnancy, one of the fundamental and immediate cause of abortion is a reality worldwide. The immediate explanation that women often give for seeking induced abortion or termination of unintended pregnancy is that the pregnancy was unplanned or unwanted (Bankole, et. al., 1998). Worldwide, about one-fourth of the approximately 180 million pregnancies known to occur each year are resolved by abortion. Abortion numbered an estimated 46 million in 1999 (26 million legal and 20 million illegal). Asia, the most populous nation of the world, has the largest total number of abortion (17 million legal and 10 million illegal) which accounts for 59 percent of the world's abortion (Henshaw, et. al., 1999).

Evidence abounds that high proportion of women become pregnant unintentionally in both developed and developing countries. In the United States and in some Eastern European countries, about one-half to three-fifths of all pregnancies are unintended and a large proportion of recent births that are unintended exceed forty percent. Even in regions where most couples will want large families, ten to twenty percent of births are unplanned (Bankole, et. al., 1998). In twenty-four out of forty-two countries surveyed however, women report an average of at least one unwanted birth

(Carr and Way, 1994). In a thorough Ethiopian study of Henz and Measham (1990) results disclosed that about one-half of the pregnancies were unwanted. The studies in Guatemala, Nepal and Uganda showed that one out of three births are unintended or unplanned.

The study of Singh et. al. (1997) revealed that unplanned birth are still common in both Bangladesh and the Philippines. In Bangladesh about one-third of all recent births were reported as unplanned pregnancies. In the Philippines, unintended pregnancies were forty-four percent, sixteen percent unwanted and twenty-eight percent mistimed. When the annual number of abortion estimated here is added to the annual births, these becomes higher, that is forty-five percent in Bangladesh and fifty-three percent in the Philippines are unplanned. Regional variations in the Philippines show highest estimate of abortions in the metropolis (41 per 1000), moderate in Luzon (30 per 1000), low in Mindanao (18 per 1000), and very low in the Visayas (11 per 1000). Study of David et al. (1998) for Family Health International (FHI) disclosed that in Region VI, out of 1100 married women of reproductive age (MWRA), 229 claimed to have experienced unintended pregnancies in Iloilo province specifically, 133 out of 369 MWRAs experienced unintended pregnancies. Of this 133 MWRAs who experienced unintended pregnancies, 98 experienced one unintended pregnancy while 35 had more than one unintended pregnancies.

The extent of maternal mortality reflects the risk of death that a woman faces on the average each time she becomes pregnant and her exposure to these risks. A woman's health substantially affects her capacity to withstand difficulties during pregnancy, childbirth, and postpartum. In many countries, avoiding unwanted pregnancy would avert

one-fourth to two-fifths of maternal deaths. More than 500,000 women throughout the world die each year from causes related to pregnancy. Ninety-nine percent of these deaths occur in developing countries and this is a tragedy for the women and their families (Safe Motherhood Initiative, 1990).

Unintended pregnancy, unsafe abortions and Sexually Transmitted Disease (STD) are among the most serious health risks that a woman faces and biological and social factors interact to make women especially vulnerable to these risks (Potts et. al., 1998). The International Conference on Population and Development in 1994, addressed the above issues, which was signed by every participating government. As the Cairo Program of Action states, unwanted pregnancy and abortion can be reduced by expanding and improving family planning services (Huntington, et. al., 1998).

Review of related studies revealed that family planning became the top priority in all countries and is expected to reduce unintended pregnancy and abortion but the results were alarmingly the opposite. In spite of the many effective contraceptive choices available today more than 50 percent of all pregnancies in the United States are unintended, and despite millions of dollars spent each year to promote birth control, the number of unintended pregnancies remains high (Boullie, et. al., 1994).

Government throughout the world has adopted the goal of "Health for all in the Year 2000". Many countries have made considerable progress toward the goal, yet maternal mortality and morbidity still represent grave threats to the survival and well being of women at the height of their productivity and family responsibility. In fact, abortion is the fifth leading cause of maternal death in Region VI (Department of Health, 1997).

Despite international calls to recognize unintended pregnancy and unsafe abortions as a serious health problem in both developing and developed countries, very little qualitative information exists at the national level. Henz and Measham (1990) cited the study of gynecological conditions in Nigeria which suggested that many places in the 3<sup>rd</sup> world countries despite all technological advances is no better than twenty years ago and will not improve until attitude toward women change. The organization of reproductive health services including family planning must be rethought and dramatically altered to give priority to women at the beginning of their reproductive career (Potts et. al., 1998).

Singh et. al. (1997) discussed that improvement in any aspect of contraceptive services would help in reducing the level of unintended pregnancy. Henshaw et. al. (1999), however, explained that unwanted and mistimed pregnancy continue to occur primarily because sexually active women who do not want a child are not using effective contraceptive methods more so because all methods are not often times used correctly. All couples should have access to information on the importance of responsible planning of family size and the many advantages of child spacing to avoid pregnancies that are too early, too late, too many, or too frequent.

In the Philippines, these high levels of unplanned pregnancy are probably the result of strong motivation of couples to control their family size and such factors have greater social conservation and ambivalence about social values.

The researcher intends to do a secondary analysis of the data that surfaced out from the original research by David, Chin and Herradura (1998) titled: "Economic and Psychosocial Influence of Family Planning in the Lives of Married Women in Western

Visayas in collaboration with Family Health International (FHI), Social Science Research Institute (SSRI), Central Philippine University (CPU), Women's Resource Center (WRC) and Family Planning of the Philippines (FPOP).

Data about unintended pregnancy and selected reproductive characteristics of MWRAs are available on this study, but no relational analysis was done on these variables because this was not part of the objectives of the study. Considering the relevance of knowing what factors may contribute to the high incidence of unintended or unplanned pregnancies, an analysis of the available data was done.

### **Major Findings of the Study**

Majority of the MWRAs were between 31-40 years old high school level, employed with 3 children. The mean age was 34 years old.

Three out of four MWRAs were satisfied with their lives as a whole. One-half to two-thirds of them participate in decision making process with their husbands specifically on wives working outside home, traveling to other places, use of family planning method and having another baby. Almost two-thirds of the MWRAs are ever user of family planning method.

Half of the MWRAs have experienced domestic violence and majority (80.32 percent) have been emotionally/psychologically abused.

MWRAS husbands are relatively younger and have a mean age of 25.43 but they are as educated as the MWRAs.

One of three MWRAs experience unintended pregnancy but majority had it only once.

MWRAs who are older (31-40 yrs. old), less educated, unemployed, having 5-6 children and are less satisfied with life as whole, experienced more unintended pregnancies than those who are younger (below 20), more educated and employed

MWRAs participating in the decision-making process with their husbands experienced unintended pregnancies.

MWRAs who practiced family planning method experienced more unintended pregnancies than non-users.

Experience on unintended pregnancies are also common among physically abused MWRAS.

MWRAs whose husbands are older and are less educated have more experience of unintended pregnancies.

### **Conclusions**

The results indicate that MWRAs age is significantly associated with their experience of unintended pregnancies whereas, education work status and satisfaction with life as a whole, have no significant bearing on their experience with unintended pregnancy.

However number of children ever born is significant to their experience of unintended pregnancies. The more children they have, the higher they have unintended pregnancies. This conforms to the study of Denton and Scott in Canada (1995) which disclosed those more children are more likely to have unintended pregnancy.

High significant association also exists between the practice of family planning method and experience of unintended pregnancy. This is however the reverse of what is



expected. The user of family planning has more tendency to experience unintended pregnancy than non-users.

The perceived participatory decision-making regarding wife's working outside the home, wife travel to other places, use of family planning and having another baby are not significantly associated to the experience of unintended pregnancy. Moreover, experience with domestic violence and type of abuse, as well as husband's age and education are not also associated with unintended pregnancy.

The findings in this study further lend support to the bio-psychosocial theory which assumes that any health or illness outcome is a consequence of the interplay of biological, psychological and social factors. If pregnancy is intended, then it is a health outcome, otherwise pregnancy is not different from any illness outcome. However, whether the pregnancy is intended or unintended, it is always on interplay of biological psychological and social factors.

### **Recommendations**

The result of the study shows significant relationship between age of MWRA's, practice of family planning, and number of children ever born and experience of unintended pregnancy among MWRA's. Practice of family planning is obviously a important factor in all these significant relationship.

Since age of MWRA's significantly relates to their experience of unintended pregnancy, family planning facilitators and health workers should encourage mothers older than 30 years to be aware of the outcome of non-use of family planning. Their choice at this stage will determine their capability to be pregnant unnecessarily.

It is further recommended that MWRA's should consider parenthood.



Another factors that has a significant bearing on the experience of unintended pregnancy among MWRA's is the number of children ever born. It is therefore recommended that family planning counseling and sources be made available to MWRA/s as early as possible in order that too close and too many pregnancies be avoided. These will also guide them on how many children they can afford to raise and take care, thus encouraging only wanted pregnancies. Husband and wife should decide to determine the size of their family based on their standard of responsible parenthood.

Family planning is highly significant to the experience of unwanted pregnancies. It is therefore recommended that consultations with government and non-government agencies on family planning protocols be adopted and implemented by the local health centers to improve and strengthen delivery of effective family planning services to MWRA's. NGOs and GOs should focus their effort not only on quantity of family planning users but on the quality and effectiveness of the method used.

Furthermore there is also a need to improve program efforts not only to motivate women to use contraception but how to use them properly. Improvement in any aspect of contraceptive services would help in reducing the level of unintended pregnancy.

More research is recommended using improved approaches to better understand the complexity of the situation and processes that lead to unintended pregnancies. The research should be able to capture the coping mechanisms or course of actions the MWRA's had with their experience of unintended pregnancy.