Influences on the decision to use contraception among Sarawakian women with diabetes: a qualitative exploration

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Abstract: Family planning is extremely important for women with diabetes due to the various health risks and other social impacts of pregnancy in this population. Unfortunately, contraceptive use among women with diabetes remains low. This study explored the reasons influencing the decision to use contraception among East Malaysian (Sarawakian) women with diabetes. This was an exploratory qualitative study conducted at an urban public health clinic in Sarawak. Purposive sampling was used to recruit 12 women with type 2 diabetes mellitus. Semi-structured in-depth interviews were audio recorded and transcribed and then subjected to interpretive thematic analysis. Five themes appear to influence the decision to use contraception: likelihood of becoming pregnant, desired family size, personal health risks associated with getting pregnant, social implications of getting pregnant, and opinions of significant others. Among Sarawakian women with diabetes, the decision to use contraception was influenced by more than just health-related factors. Contraception counselling for this group of women should factor in their health beliefs, personal values, and social factors. Community involvement and peer support are potential strategies to improve contraception use. DOI: 10.1080/09688080.2019.1571316

Keywords: family planning, contraception counselling, contraception use, contraception behaviour, diabetes mellitus, qualitative studies, Malaysia

Introduction

Family planning is an essential component of pre-conception care for women with diabetes mellitus (DM). Delaying pregnancy until achievement of the best possible glycaemic control improves pregnancy outcomes and avoids serious health risks to both mother and baby.1–3 Unfortunately, the rates of contraception use among women with DM are low. Less than half of women with DM surveyed were using contraception, despite having no intention of becoming pregnant.4 In Malaysia, despite the wide availability of contraception services even in remote rural health clinics, the use of contraception among women with DM is 28.8%, even lower than the general female population, which is 35% for modern contraception.5,6 This is a major cause of concern owing to the attendant risks of an unplanned pregnancy.

Reasons for not using contraception have been explored in various countries. Among the patient factors are lack of knowledge regarding pregnancy risks associated with chronic medical illness, pre-conception health, and understanding how medical conditions might affect contraceptive choices.7 Service-related factors include contraception provision and advice7 as well as patients’ relationships with health care providers.4 Contraceptive practices are also influenced by socio-cultural factors such as religious prohibition, spousal opposition, support from significant others, and marriage satisfaction.4,8 Whether similar factors can accurately explain contraceptive practices among the multi-ethnic local Malaysian population is yet to be investigated.

Sarawak is the biggest state in Malaysia, with a large proportion of its population consisting of indigenous ethnicities, besides the three main
Methods

Ethical approval for conducting this study was obtained from both the Malaysian Ministry of Health Medical Research and Ethics Committee (NMRR-15-1281-26768) and the Universiti Kebangsaan Malaysia Medical Centre Medical Research and Ethics Committee (FF-2015-375).

This was an exploratory qualitative study conducted from December 2015 to September 2016 among women with DM who attended a public primary care clinic in Sarawak, East Malaysia. The study attempted to provide descriptive themes to cover the possible range of reasons for contraceptive use. This clinic serves a multi-ethnic population consisting of Chinese, Malay, and various indigenous ethnic groups. Most patients are from lower-to-middle income groups. The clinic provides general outpatient services for men and women, including chronic disease care such as diabetes. The Maternal and Child Health service provides antenatal and postnatal care, including family planning, as well as child health services.

Study participants were sexually active, adult, pre-menopausal females (aged 18 years and older) with type 2 DM. Women who could not converse in English, Malay, or Mandarin, who had cognitive impairments, or were formally diagnosed with psychiatric disorders, were excluded from the study. Women who were post-menopausal or had undergone hysterectomy were also excluded. Purposive sampling was done to ensure a balanced representation of women who used contraception and those who did not. We also asked participants whom we interviewed to recommend their friends or relatives who fulfilled the criteria. This was done because discussing contraceptive use was a private issue in the local culture, leading to difficulty in recruiting participants. Recruitment of participants continued until data saturation.

In-depth interviews were arranged upon receipt of formal written consent from the participants. The interviews were conducted in a private room in the clinic, in either English or Malay, based on each participant’s preference. These interviews were audio recorded with the participant’s consent. Each interview lasted between 30 and 60 min. The interviewer (DLSC) utilised a semi-structured topic guide that was developed based on the constructs of the Health Belief Model. The questions in the topic guide are shown in Table 1. Interviews were transcribed into either English or Malay. All three researchers were proficient in both languages.

The qualitative data were subjected to thematic analysis using NVIVO 10 (QSR Ltd) to aid in data management. Through an analysis of the semantic content, we aimed to identify patterns in the reasons for contraceptive use. The transcript of the first interview was independently coded by all three researchers and the codes were discussed to obtain agreement. Subsequent transcripts of the interviews were coded by one researcher (DLSC). The coding allowed for bilingual data entry. The coding was then reviewed by two other researchers (TCE and TSF). Regular meetings were held among the three researchers to discuss the coding and all disagreements were resolved via consensus. All three researchers read the transcripts to familiarise themselves with the content and context of the interviews. Free coding was completed for the first round of analysis of the first three interviews. We did not assume any particular theoretical underpinning or concepts in this initial stage of analysis. The second round of coding utilised this set of categories to code the subsequent transcripts. Any new categories that emerged were discussed before they were added to the list. This paper focuses on findings on contraceptive use and choice.

Data saturation, where no new themes were detected, was achieved by the tenth interview and confirmed by analysis of two additional interviews. DLSC and TCE were familiar with the community being studied, adding to the understanding of participants’ responses. All...
| Table 1. Interview topic guide |
|-------------------------------|
| **Preamble**                 |
| Can you tell me about your diabetes? |
| When and how was it diagnosed? |
| What treatment did you receive? |
| Can you tell me about your diabetes control? |
| How do you space out your pregnancies? How do you feel about it? |
| **General questions about contraceptive use** |
| Could you share what you understand about family planning? |
| Please share your views about the various types of family planning methods that you know of. |
| Could you share your reasons for using your current family planning method? |
| Who decides the type of family planning method that you use? |
| How do you decide the type of family planning method to use? |
| **Perceived seriousness/severity** |
| Can you share what you know about the effects of diabetes on pregnancy? |
| What do you understand about the effects of pregnancy on your diabetes? |
| Can you share your opinion about the effects if you became pregnant, since you have diabetes? |
| **Perceived susceptibility** |
| What do you think are the chances of you getting pregnant with/without contraception? |
| What do you think is the likelihood of you developing the conditions that you mentioned if you got pregnant? |
| **Perceived benefits of contraceptive use** |
| How do you think using contraception will affect you and your family? |
| **Perceived barriers to contraceptive use** |
| What makes family planning less desirable or difficult for you? |
| What makes it easier for you to practise family planning? (Lack of barriers) |
| Could you share with us your reasons for choosing not to practise family planning? |
| Could you share with us your reasons for stopping family planning? |
| **Cues to action** |
| How does the doctor or nurses’ advice affect your decision to practise family planning? |
| How do others (friends and family, health care providers, mass media) affect your motivation to practise family planning? |
| **Self-efficacy** |
| How confident are you that you are able to practise family planning correctly? |
| What makes you more confident in practising family planning? |
researchers were primary care doctors who managed patients with DM. We maintained reflexivity during analysis by keeping memos regarding personal awareness of any possible bias or assumptions. The list of themes was also presented to other academics in family medicine who were not involved in the study to be scrutinized and ensure the credibility of data analysis.

Results

The 12 participants ranged in age from 23 to 51 years. The women represented a mix of ethnicities, including indigenous Iban and Bidayuh ethnic backgrounds (see Table 2). While the majority were homemakers at the time of the interview, a few had histories of employment. Most of the participants had obtained secondary school education. Approximately half of the participants reported that they were using some form of contraception at the time of the interview, but fewer were using modern contraceptives. All except one already had children.

There were five main themes related to the decision to use contraception: the perceived likelihood of getting pregnant, desired family size, personal health risks associated with becoming pregnant, social implications of getting pregnant, and opinions of significant others (see Table 3). Of these, only the theme of personal health risks of getting pregnant appeared to be related to a diagnosis of DM.

Perceived likelihood of getting pregnant

The participants’ personal perceptions about their likelihood of conceiving influenced their decision to use contraception. This perception appeared to be unrelated to their actual likelihood of getting pregnant. This is of concern as some of them may actually falsely perceive themselves to be less likely to conceive and thus choose not to use contraception. For example, P5 had not used any modern contraception since her last childbirth. She perceived herself to be infertile following consumption of some traditional medicine that was meant to sterilize her. There was no evidence that the traditional medicine was reliable or would permanently leave her infertile. She did not use any contraception because she had not conceived since and had faith that the medicine was truly effective. Conversely, P1, a peri-menopausal participant, still used contraception despite having a lower likelihood of pregnancy. Therefore, the perceived likelihood of pregnancy influenced the decision to use contraception, independent of actual risk of pregnancy.

Desired family size

Participants’ need to space out their pregnancies and their desired family sizes also influenced the decision to use contraception. Women who had reached their desired family size decided to use more permanent forms of contraception. The agreed number of children appeared more important than their diabetes for some participants.

Pregnancy-related health risks

Some participants expressed concerns pertaining to the effects of DM during pregnancy. From their past collective experiences of antenatal and postnatal care, they had learned about the risks of DM on their pregnancy and babies. Some participants reported that having DM during pregnancy required more frequent medical monitoring, and some perceived this as burdensome. Participants’ past experiences of the delivery process also influenced their decision to use or abstain from contraception. Those who underwent a “difficult” labour, such as a prolonged labour, induced labour, or caesarean sections, mentioned that the experience influenced their decision to use contraception.

Despite knowledge and past experiences, participants in the present study did not have a thorough understanding of the risks from DM on pregnancy, and they could not offer any specifics. Specifically, they frequently mentioned concerns of having “abnormal” or “big” babies, but they did not mention other risks such as miscarriage, intrauterine death, and neonatal complications. Nevertheless, their limited knowledge appeared to partially influence their decision regarding contraceptive use.

Social effects of getting pregnant

The idea of becoming pregnant, and the subsequent responsibility of raising a child, elicited various responses from the women. Those who believed that becoming pregnant would negatively affect financial or advancement opportunities preferred to use contraception.
Participant P9 was not using contraception at the time of the interview. However, she did not want to conceive as she was still studying and did not want to be burdened with having children at that point of time. She had requested her boyfriend to purchase contraceptive pills for her; however, he did not do so. Instead, they practised coitus interruptus, which is not a reliable form of contraception. P11 did not want to become pregnant because of the financial burden, but at the same time, did not use contraception because she perceived herself to be unlikely to get pregnant.

**Opinions of significant others**
The participants’ decisions to practise contraception were also greatly influenced by important people in their lives, such as respected older female relatives, friends, health care personnel, or even their religious leaders. They reported that the reasons for practising contraception depended on the recommendations of these people.

**Discussion**
Among women with DM, the decision to use contraception was made after weighing the risks against the benefits of contraceptive use. Only one theme appeared to be related to having DM, highlighting the influence of other social determinants of health on their contraceptive behaviours.12

The women in the study viewed their own ability to conceive in different ways. Past studies have shown that many women have inaccurate perceptions of their own fertility, regardless of whether they are from developed or developing countries.13,14 This could be owing to lack of knowledge regarding their actual fertility status. Some women in this study assumed that they

| No. | Age (years) | Ethnicity | Employment status | Level of education | Current contraception use/method |
|-----|-------------|-----------|-------------------|-------------------|----------------------------------|
| 1   | 51          | Chinese   | Employed          | Tertiary          | Condom                           |
| 2   | 47          | Malay     | Homemaker (previously employed) | Secondary         | IUCD                             |
| 3   | 37          | Iban      | Homemaker         | Secondary         | BTL                              |
| 4   | 42          | Malay     | Homemaker         | Secondary         | Coitus interruptus               |
| 5   | 31          | Chinese   | Homemaker (previously employed) | Secondary         | Traditional medicine             |
| 6   | 36          | Bidayuh   | Homemaker (previously employed) | Secondary         | POP                              |
| 7   | 27          | Bidayuh   | Homemaker (previously employed) | Secondary         | IM MPA                           |
| 8   | 46          | Iban      | Homemaker         | Primary           | BTL                              |
| 9   | 23          | Malay     | Student            | University        | None (Previously coitus interruptus) |
| 10  | 36          | Iban      | Homemaker         | Secondary         | None (Recently stopped using IM MPA) |
| 11  | 40          | Malay     | Homemaker         | Secondary         | None                             |
| 12  | 41          | Bidayuh   | Homemaker         | Secondary         | None                             |

Note: IUCD = intrauterine contraceptive device, BTL = bilateral tubal ligation, POP = progesterone-only pills, IM MPA = intramuscular medroxyprogesterone acetate
### Table 3. Themes related to the decision to practise contraception, with examples of related quotes

| Perceived likelihood of getting pregnant |
|----------------------------------------|
| “Well, I think at my age, I think the percentage (of getting pregnant) is very low. I just started having irregular (periods) you know. I am just starting my menopause, so I don’t want to take that risk”. (P1, a 51-year-old Chinese woman) |
| “I have not used contraception for a long time. Since my last childbirth in 2009 until now, I have not used any contraception. No effect (getting pregnant) at all … because my mother gave me some traditional medicine, to stop me from conceiving again, seeing that I am sick”. (P5, a 31-year-old Chinese woman) |

| Desired family size |
|---------------------|
| “I asked the doctor, ‘Can I have my tubes tied? I don’t want to have children anymore; my children are older and have entered kindergarten’. The doctor said yes”. (P8, a 46-year-old Iban woman) |
| “No. I don’t think my diabetes has anything to do with it [family planning]. Because when we got married, we had already discussed how many children we wanted … So it’s already fixed and just want to have two. So I don’t think [diabetes] has anything to do with family planning.” (P1, a 51-year-old Chinese woman) |

| Personal health risk of getting pregnant |
|-----------------------------------------|
| a. Negative effects of diabetes on pregnancy |
| “When I reflect on my own life, my first pregnancy ended in a miscarriage, my second passed away. So, after this, I have to plan properly so my pregnancy will be successful”. (P7, a 27-year-old Bidayuh woman) |
| “Many things happened when I got pregnant, all sorts of things. Checking blood sugar for one week, a few times each month. Seven times (checking sugar) is a burden … need to buy … what’s that (glucose strips), buy it on my own”. (P10, a 34-year-old Iban woman) |
| b. Anticipated difficulty during the delivery process |
| “About pregnancy, I am afraid of going through the operation again. Oh, big baby, afraid of disabled or syndromic baby; I am afraid of that”. (P11, a 40-year-old Malay woman) |

| Social implications of getting pregnant |
|----------------------------------------|
| a. Financial burden of raising another child |
| “That is why I don’t want to get pregnant again; my husband has difficulty earning a living”. (P11, a 40-year-old Malay woman) |
| b. Personal freedom to focus on other priorities |
| “I am doing my degree programme now; I want a good job, earn a salary after that, and my husband will also be working. If I have many children, who will take care of them? I do not want to trouble my mother-in-law, my own mother”. (P9, a 23-year-old Malay woman) |

| Opinion of significant others (including family members and friends, healthcare personnel, religious leaders) |
|------------------------------------------------|
| “After I had my second child, my sister-in-law recommended that I start family planning because she said my pregnancies were too close”. (P2, a 47-year-old Malay woman) |
| “Arr … because the doctor advised us to use (contraception) because he is afraid (of risks of getting pregnant again) … must wait for three years (after the caesarean section) before I conceive again”. (P3, a 37-year-old Iban woman) |
| “Hmm … I tried … once I tried to ask my boyfriend to buy contraceptive pills for me … but my boyfriend just encouraged me and said I won’t get pregnant … he won’t ejaculate inside me … so I trusted him”. (P9, a 23-year-old Malay woman) |
were unlikely to get pregnant because they had not conceived over the past few years. They were not aware that they could still conceive although their fertility may have declined. This phenomenon is of great concern since it may lead to the poor uptake of contraception, particularly among women with DM.\textsuperscript{15} Health care providers should therefore discuss pregnancy periodically with their patients with DM to help prevent unplanned pregnancies.

Desired family size can act as a facilitator or barrier to contraceptive use. The desired family size is influenced by socio-economic factors such as a woman’s level of education, child’s survival up to five years, and household per capita income.\textsuperscript{16} In some countries, the desired family size may also be associated with the number of sons.\textsuperscript{17} Health care providers should take this into account when counselling women with DM about family planning. Ideally, informed and shared decision-making would be employed to allow the woman to achieve the desired family size while optimising glycaemic control prior to conception.

Participants in this study were aware of some of the health risks associated with pregnancy. Almost all had given birth before, and thus had been through the experience of being pregnant while also managing their DM. During antenatal care, the participants had received education from physicians and nurses about the diabetes-related health risks to themselves and their babies. The negative effects of DM on their pregnancy necessitated additional monitoring and labour induction at term. For these reasons, after their first pregnancy, many of these women subsequently used contraception and attempted to improve control of their DM before becoming pregnant again. This finding was also supported by prior studies in which women who were aware of and concerned about DM-related pregnancy complications delayed becoming pregnant until their health was under better control.\textsuperscript{18} Although the participants knew that DM increases health risks during pregnancy, their knowledge regarding the exact risks was below expectations. In particular, the women in the study were only able to report one or two specific risks. This finding highlights the poor knowledge about the antenatal and postnatal complications of uncontrolled DM and is aligned with past research.\textsuperscript{19} As such, more efforts are needed to educate female patients with DM regarding pregnancy-related health risks even before they consider becoming pregnant.

The implication of having another child also affected participants’ decisions to use contraception. They mentioned the financial burden that comes with the responsibility of raising another child and the loss of freedom to pursue other priorities such as working. Costs of feeding and clothing children were also mentioned as factors influencing contraceptive usage in other Asian countries.\textsuperscript{20} The role of childcare has traditionally been the duty of mothers, limiting their ability to find gainful employment. Indeed, many participants in the current study reported that they stopped working after having children. Some participants with older children intended to seek employment to supplement their household income; thus, having another child would infringe on these plans. Overall, the social implications of pregnancy influence the decision to use contraception, since having another child can have financial implications.

The participants in the current study reported that advice from important people within their social network influenced their decisions to use contraception. Past studies have demonstrated similar findings where family and peer support were associated with contraception use behaviours.\textsuperscript{21,22} Therefore, developing a peer support group to encourage family planning among women with DM might promote better reproductive knowledge and awareness. This is especially true among Malaysians due to their collectivist culture and tendency to seek advice from peers regarding personal issues.\textsuperscript{23}

The Malaysian health care system has an antenatal care system that categorises women according to their obstetric risks, including women with diabetes. Most pregnant women are categorised as having low obstetric risk. Specifically, patients with DM are identified by code and are subsequently seen by physicians during each antenatal visit. Community nurses also provide structured advice to these women during the antenatal period. Hence, healthcare professionals have an important role in advocating for contraception use. Negative experiences with health care professionals could result in failure to attend pre-pregnancy clinics, leading to unplanned pregnancies.\textsuperscript{21} In another study, two-thirds of women were not able to remember discussing pregnancy or contraception with a health care provider.\textsuperscript{19} It is reassuring that the participants in the present study did not express dissatisfaction with their health care providers.
In many other countries, studies have shown that the equity gap affected the population's contraceptive prevalence rate, with contraceptive use lowest among those from the lowest wealth quintiles. While this study cannot be generalised to the national population, the direct cost of contraceptives was not mentioned as one of the reasons for using or not using contraceptives. This may be because contraception is available at public maternal and child health clinics in the country at a nominal rate of RM 1 (equivalent to approximately USD 0.23) per visit. Contraception is also available from other sources such as retail pharmacies and private primary care clinics, albeit at a higher cost, for patients who prefer more privacy and convenience. Larger-scale studies on generalisable populations are needed to determine the association of financial status with the decision to use contraception.

To the best of our knowledge, this was the first qualitative study to explore the reasons for contraceptive use and avoidance among women with DM in Sarawak, East Malaysia. The qualitative nature of the study allowed better insight into the reasons that influence decisions on contraception use among women with DM, complementing the findings of past quantitative studies from the same region. A wide variety of participants of various ages, ethnicities, and contraceptive use practices allowed us to explore the breadth of reasons for contraception use or avoidance. The main limitation of this study was the limited recruitment base as participants identified were from just one public health clinic in Sarawak. Hence it may not be fully transferable to women in the general population. The qualitative study design did not allow for measurement of the degree of influence of each theme that was uncovered. DLSC was a doctor in the clinic, which could lead to some degree of response bias. However, this was controlled by ensuring that she did not proceed to manage the patients' consultation at the clinic.

Conducting other anthropological studies may provide new insights from a sociocultural viewpoint to complement public health initiatives, as well as to identify potential solutions and recommendations that would be culturally appropriate. A follow-up quantitative study of these themes may be beneficial for identifying the most influential reasons and for guiding policy-makers on public health interventions to improve contraceptive use in this population. Future research may determine the accuracy of women's self-perception of their fertility status and the level of knowledge regarding risks of pregnancy in women with diabetes.

In conclusion, the decision to use contraception among Sarawakan women with DM in Kuching, East Malaysia is influenced by more than just health-related factors. Contraception counselling for this group of women should factor in their health beliefs, personal values, and social factors. Community involvement and peer support are potential strategies to improve contraception use. Incorporating social sciences and anthropological knowledge into the various public health initiatives may enhance these efforts and improve women’s health in this community.

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References

1. Kitzmiller J, Buchanan T, Kjos S, et al. Pre-conception care of diabetes, congenital malformations, and spontaneous abortions. Diabetes Care. 1996;19:514–541.

2. Willhoite MB, Bennert HW, Palomaki GE, et al. The impact of preconception counseling on pregnancy outcomes: the experience of the maine diabetes in pregnancy program. Diabetes Care. 1993;16:450–455.
3. Macintosh MCM, Fleming KM, Bailey JA, et al. Perinatal mortality and congenital anomalies in babies of women with type 1 or type 2 diabetes in England, Wales, and Northern Ireland: population based study. Br Med J. 2006;333:177.

4. Holing E V, Beyer CS, Brown ZA, et al. Why don't women with diabetes plan their pregnancies. Diabetes Care. 1998;21:889–895.

5. Najimmudeen M, Sachchithanantham K. An insight into low contraceptive prevalence in Malaysia and its probable consequences. Int J Reprod Contraception, Obstet Gynecol. 2014;3:493–496.

6. Manaf RA, Ismail IZ, Latiff La. Contraceptive use among women with chronic medical conditions and factors associated with its non-use in Malaysia. Glob J Health Sci. 2012;4:91–99.

7. Shawe J, Smith P, Stephenson J. Use of contraception by women with type 1 or type 2 diabetes mellitus: “it’s funny that nobody really spoke to me about it”. Eur J Contracept Reprod Health Care. 2011;16:350–335.

8. Mekonnen TT, Woldeyohannes SM, Yigzaw T. Contraceptive use in women with hypertension and diabetes: cross-sectional study in northwest Ethiopia. Int J Womens Health. 2015;7:957–964.

9. Khoo EM, Cheong AT, Liew SM, et al. The changing face of health education: theory, research and practice. San Francisco: Jossey-Bass; 1997.

10. Stretcher V, Rosenstock IM. The health belief model. In: Holing E V, Beyer CS, Brown ZA, et al. Why don’t women with diabetes plan their pregnancies. Diabetes Care. 1998;21:889–895.

11. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3:77–101.

12. Rasanathan K, Damji N, Atsbeha T, et al. Ensuring contraception chez les femmes diabétiques en les raisons in faible chez ces femmes. L’affaire d’amélioration de la santé des femmes diabétiques. Papier de travail.-br. Reprod Health. 2011;37:209–216.

13. Jayaraman A, Mishra V, Arnold F. The Relationship of family size and composition to fertility Desires, contraceptive adoption and method choice in South Asia. Int Perspect Sex Reprod Heal Sex Reprod Heal Guttmacher Institute. 35;2009:29–38.

14. Lundsberg LS, Pal L, Gariepy AM, et al. Knowledge, attitudes, and practices regarding conception and fertility: a population-based survey among reproductive-age United States women. Fertil Steril. 2014;101:767–774.e2.

15. St. James PJ, Younger MD, Hamilton BD, et al. Unplanned pregnancies in young women with diabetes: An analysis of psychosocial factors. Diabetes Care. 1993;16:1572–1578.

16. Bongaarts J. Can family planning programs reduce high desired family size in Sub-Saharan Africa? Int Perspect Sex Reprod Health. 2011;37:209–216.

17. Jayaraman A, Mishra V, Arnold F. The Relationship of family size and composition to fertility Desires, contraceptive adoption and method choice in South Asia. Int Perspect Sex Reprod Heal Sex Reprod Heal Guttmacher Institute. 35;2009:29–38.

18. Spence M, Alderdice FA, Harper R, et al. Education and psychological aspects an exploration of knowledge and attitudes related to pre-pregnancy care in women with diabetes. Diabet Med. 2010;27:1385–1391.

19. Cartwright A, Wallymahmed M, Macfarlane I, et al. What do women with diabetes know about pregnancy and contraception ? Pr Diab Int. 2009;26:238–242.

20. Woollett A, Dosanjh-matwala N, Hadlow J. Reproductive decision making: Asian women’s ideas about family size, and the gender and spacing of children. J Reprod Infant Psychol. 1991;9:237–252.

21. Murphy HR, Temple RC, Ball VE, et al. Personal experiences of women with diabetes who do not attend pre-pregnancy care. Diabet Med. 2010;27:92–100.

22. Nathanson CA, Becker MH. Family and peer influence on obtaining a method of contraception. J Marriage Fam. 1986;48:513–525.

23. Jan JM, Pung CW. Strategies used and cultural considerations in seeking advice on in-vitro fertilisation online: a case of Malaysian women. 3L Lang Linguist Lit. 2016;22:1–16.

24. Ross J. Improved reproductive health equity between the poor and the rich: An analysis of trends in 46 low- and middle-income countries. Glob Health Sci Pract. 2015;3:419–445.

Résumé
La planification familiale est extrêmement importante pour les femmes diabétiques, en raison de plusieurs risques sanitaires et d’autres impacts sociaux de la grossesse dans cette population. Malheureusement, l’emploi de contraceptifs reste faible chez ces femmes. L’étude s’est penchée sur les raisons influençant la décision d’utiliser une contraception chez les femmes diabétiques en Malaisie orientale (Sarawak). Il s’agissait d’une étude sénatale et un questionnaire a été distribué aux femmes diabétiques. Les résultats indiquent que la planification familiale est extrêmement importante pour les femmes diabétiques en Malaisie orientale.
étude qualitative exploratoire menée dans un centre urbain de santé publique à Sarawak. Un échantillonnage dirigé a permis de recruter 12 femmes avec un diabète de type 2. Des entretiens approfondis semi-structurés ont fait l’objet d’un enregistrement audio, puis ils ont été transcrits et soumis à une analyse thématique interprétative. Cinq thèmes semblent influencer la décision d’utiliser la contraception: la probabilité d’une grossesse, le nombre d’enfants souhaités, les risques sanitaires personnels associés à une grossesse, les conséquences sociales d’une grossesse et les opinions de personnes importantes pour ces femmes. Chez les femmes diabétiques à Sarawak, la décision d’utiliser une contraception n’a pas été influencée seulement par des facteurs en rapport avec la santé. Les conseils sur la contraception pour ce groupe de femmes devraient tenir compte de leurs croyances en matière de santé, de leurs valeurs personnelles et des facteurs sociaux. La participation de la communauté et le soutien des pairs sont des stratégies potentielles pour améliorer l’emploi de la contraception.

Este estudio cualitativo exploratorio fue realizado en una clínica de salud pública urbana. Se empleó una muestra deliberada para reclutar a 12 mujeres con diabetes mellitus tipo 2. Entrevistas semiestructuradas a profundidad fueron grabadas en audio, transcritas y sujetas a análisis temático interpretativo. Al parecer, cinco temas influyen en la decisión de usar anticoncepción: la probabilidad de quedar embarazada, el tamaño de familia deseado, los riesgos para la salud personal asociados con quedar embarazada, las implicaciones sociales de quedar embarazada y las opiniones de las parejas. Entre las mujeres sarawakianas con diabetes, la decisión de usar anticoncepción fue influenciada por más que simplemente factores relacionados con la salud. La consejería anticonceptiva para este grupo de mujeres debe tomar en cuenta sus creencias sobre la salud, sus valores personales y los factores sociales. La participación comunitaria y el apoyo de pares son posibles estrategias para mejorar el uso de anticoncepción.