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Sexual and birth control health practices among female undergraduates: a descriptive study

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ABSTRACT

Aim: To describe the sexual and birth control health practices of Brazilian female undergraduates and compare them according to family income. **Method:** This is a descriptive study of a sample of eighty female public university students, using the chi-square test, with a significance level of $p<0.05$, and modified contingency coefficient. **Results:** Female undergraduates with lower incomes initiated their sex lives between the ages of 14 and 16 years (53.3%), used protection in their first sexual experience (80%) and used public health services (66.7%). Those with higher incomes started their sex lives at the age of 17 years old or more (64.7%), their first sexual intercourse was unprotected (35.3%), and they used the private health network (88.2%). **Discussion:** The level of family income does not influence access to sexual and reproductive health in the investigated sample. **Conclusion:** There are differences in the type of service provider used between those with different family incomes.

Descriptors: Women's Health; Family Planning; Birth Control.

INTRODUCTION

Social determinants, such as education, health, income, culture and gender influence the sexuality of young Brazilians. The idea that men and women have different sexual interests and needs generates a powerful set of beliefs about female sexuality, which determines social and behavioral standards that are different for men and women[1].

In Brazilian sexual culture, there is a reinforcement of gender stereotypes, which creates a barrier to the adoption of preventive measures regarding unwanted pregnancy. Youngsters find it more difficult to negotiate the use of male protection, as it involves feelings of trust between partners and depends on the duration of the relationship[2].

The Brazilian fertility rate decreased substantially towards the end of the 20th century due to changes in society, especially the spread of oral birth control methods and changes in the role of women in contemporary society. Initially this reduction started among the most advantaged social strata, but in recent decades, it has spread to other social classes[3].

After 2000, there was a decrease in the birth rate of Brazilian women; however it was less significant among women between 15 and 19 years old. In 2000, this age group accounted for 22.5% of mothers, decreasing to 20.6% in 2006[3].

In Brazil, the average age of sexual initiation is 15 years old. Among boys, there is a predominance to believe sex is a physical instinct and an uncontrollable desire. Teenage girls consider sexual initiation to involve an intrinsic relationship between love, desire and sex[4].

Access to family planning is a reproductive right that must be guaranteed to exercise autonomy over whether or not to have children. In order to guarantee this right, the health service network must provide conception and contraception assistance as part of its holistic health care service role, and without any restriction by gender.

In reproductive health services, there are social factors that can interfere in assistance to youngsters, such as social inequality in gynecological care. Women from lower strata's of society, with less education, feel more embarrassed during consultations and there exists an unbalanced power relationship with the professional who supports them in the public health services[5].

Women with higher incomes and higher levels of education, who are frequently assisted by the private supplementary health system, have a less asymmetric relationship with the health professional, and the motivation of the first gynecological consultation is more related to acquiring information and to adopting preventive measures[5].

We can relate the use of birth control methods directly to the level of education. The use of male protection is higher among undergraduates during their first and second years, while undergraduates in their final year prefer to use oral birth control methods. We see this change as a reflection of the increase of more stable relationships among undergraduates in their final year[6].

Undergraduates tend to postpone the beginning of their sex lives, which usually coincides with the beginning of their college lives, and eventually they do not adopt the use of birth control methods in their sexual intercourses[6].

We also find this behavioral characteristic in North-American undergraduates, who declared casual sexual relationships with different partners and irregular use of protection.

Such behavior is risky to sexual and reproductive health, demanding, from the college community, the organization of educational and health promotion strategies[7].

This complex problem is influenced by social determinants, such as gender, income and education, and in this study we aim to describe the sexual and birth control practices of female undergraduates who have recently arrived at university, and to compare these practices according to these determinants.

METHOD

This is descriptive research, using a qualitative approach, which we performed in a public university in the city of Rio de Janeiro, Brazil. We used a sample of women who recently entered two undergraduate programs: one in the Area of Education (AE) and the other in the Area of Health (AH). This study was approved by the Ethics in Research Commission of Rio de Janeiro State University, under protocol 042.3/2011.

According to the statistical directory of this university, the population of the institution for the year 2009 shows 23,673 active undergraduates, divided into 32 undergraduate programs. Among this total, 12,450 (52.6%) students are female, of which 4,276 (34.3%) entered through the quota system.

In this university, 45% of all available places on undergraduate programs are for students on the quota system, who can prove low family incomes. Under this system, 20% of places are provided for those who study in public high schools, 20% to Afro-decedents, and 5%, to native-Brazilians, physically disabled people, children of civil and military police servicemen, military firefighters, and penitentiary inspectors and administrative

personnel, or those deceased or incapacitated in action.

We made the choice of which undergraduate programs to collect data from based on the statistical directory. In the AE program, women represent 84.6% of enrolled students, and in the AH program, 80.6%. The proportion of non-quota undergraduate students in the AE program, whose family income was above three minimum wages (mw), was 28.09%, while in the AH program, this group represents only 6.45%. The predominance of women and the disparity of the profile of family gross incomes were the preliminary criteria of the adopted selection.

According to the data provided by the registry office from both undergraduate programs, there were 322 female students in the first and second semesters of the AE program, and 48 women enrolled in the AH program, a total of 370 enrolled in the first year of these undergraduate programs.

After these delimitations, we considered a female participant eligible, if they met our inclusion criteria of being between the ages of 19 and 24 years, enrolled on the first year of the chosen undergraduate programs, nulliparous, and who had already initiated their sex lives. We excluded from the study, those women who were not actively enrolled, who had children or who had not started their sex lives.

The variables for this study are, social, economic and healthcare access profile (age, marital status, skin color, location of the high school, family income, main source of income, type of healthcare service used, evaluation of healthcare access); sexual health (first intercourse, use of contraception, gynecological consultation at the beginning of sexual activity, type of sexual relationship); birth control practices (types of birth control

used, local acquisition of method, occurrence of unplanned pregnancies and volunteering interruption of pregnancy).

We used a structured questionnaire, consisting of 25 closed questions, and ignored the data collected from the pilot test. We issued 132 questionnaires between August and November 2011, of which 52 (39.4%) were discarded due to negative answers regarding the beginning of their sexual lives.

At the end of the data collection, we sent the information to a computer data bank, where it was transformed into tables and subjected to descriptive statistical treatment. We analyzed the data using a chi-square test, taking into consideration a level of significance of $p<0.05$. To observe the association among the categories, we calculated the coefficient of modified contingence (C*), which varied from zero to one. The values of C* near zero indicate a weak association, and values near one demonstrate a strong association. The values of C* around 0.5 demonstrate a moderate association.

RESULTS

In this research study sample, there are a total of 80 participating female undergraduates. Among these, 56.3% are between the ages of 19 and 20 years, 32% are between 21 and 22 years old 12.5% are between 23 and 24. Almost all are single (92.5%), and the rest are in a relationship or married. They mostly declare themselves as white (56.3%); other answers include brown (22.5%), black (18.7%) and Asian (2.5%). There is also a predominance of undergraduates from public schools (53.8%), compared to those from private institutions.

With regards to family income, we used the Brazilian national minimum wage (mw) as a yardstick, which was R$ 545.00 in 2011. The greatest number of undergraduates (38.8%) are in the income level between three and four mw, followed by those between five and six mw (21.2%). 18.8% are in the income bracket between one and two mw (18.8%), and ten per cent between seven and eight mw. The income levels of "between nine and ten mw" and "more than ten mw" have the lowest frequencies, of 5% and 6.2%, respectively.

We took the source of income into consideration, and the number of students formally employed is close to the number of undergraduates who receive some sort of allowance (33.7% against 32.5%). When we match this information with the data from family income, there is a larger difference in the distribution of women that depend mainly on resources from their families. The number of female undergraduates with family incomes above six mw was 70.5%. We did not find any meaningful statistical differences between the sources of income and family income.

There is a divergence in the distribution of income by the level of family income and type of healthcare service. The group of undergraduates with family incomes below three mw use public healthcare services the most (66.7%). While students with family incomes above 6 mw mainly use private healthcare services (88.2%). There is a meaningful statistical difference between the type of service used and family income.

Taking into consideration the evaluation we performed regarding access to healthcare services, those that belong to the group where family income levels are three, mw rank access as "hard" (20%) or "very hard" (20%). Among the undergraduates who evaluate access as "easy", the majority is in the group whose family income level is above six mw. In the group with income levels between three

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Table 1 - Distribution of female undergraduates by family income level according to the main source of income, type of healthcare service and evaluation of access to care. Public university. Rio de Janeiro, Brazil, 2011.

Variables	Less than 3 m.w.		From 3 to 6 m.w.		More than 6 m.w.		Total		p-va-lue	C*
	f(15)	%	f(48)	%	f(17)	%	f(80)	%		
Resource type									0.226	0.6
Family allowance	3	20	11	22.9	12	70.5	26	32.5		
Alimony	1	6.7	1	2.1			2	2.5		
Scholarship	3	20	9	18.8			12	15		
Informal job	2	13.3	6	12.5	1	5.9	9	11.3		
Formal job	5	33.3	18	37.5	4	23.6	27	33.7		
Freelancer	1	6.7	3	6.2			4	5		
Type of healthcare									0.0001	0.7
Public	10	66.7	8	16.7			18	22.5		
Healthplan membership	2	13.3	37	77.1	15	88.2	54	67.5		
Private(*)	3	20	3	6.2	2	11.8	8	10		
Evaluation of access to health-care									0.075	0.6
Very easy					2	11.7	2	2.5		
Easy	2	13.3	15	31.2	9	53	26	32.5		
Neither easy, nor hard	7	46.7	23	48	6	35.3	36	45		
Hard	3	20	7	14.6			10	12.5		
Very hard	3	20	3	6.2			6	7.5		

Key: minimum wage (m.w.)
(*) paid upon service
Source: Designed by the authors, 2013

and six mw, the prevalence of results demonstrates that access is "not easy, nor hard", despite the fact that the majority, (77.1%), use private supplementary healthcare services. There is no significant statistical difference between the income levels for the variable "evaluation of access to healthcare service". We show this data set in Table 1.

We can see that 5.5% of female undergraduates initiate their sexual activity between 17 and 19 years of age. Comparing their family incomes, those with lower incomes (below three mw) have their first sexual intercourse earlier than the rest, at between 14 and 16 years old (53.3%).

With regard to the use of protection during their first experience of sexual intercourse, the majority (73.8%) use this type of protection. However those with higher family income levels (above six mw), have a higher rate (35.3%) of unprotected sex during their first intercourse. In all income levels, 73.7% of the female undergraduates search for gynecological care when initiating their sex lives. There is no significant statistical difference between levels of family income, as we observe in Table 2.

The types of sexual relationships vary; with the majority (72.5%) having a stable partner, followed by those who have sex with someone who eventually becomes their partner (8.7%) and those who have sex with more than one partner (2.5%). Among the women whose family income is above six mw, there was the largest numbers (17.6%) who have sex with casual partners, compared to other income groups. There was no significant statistical difference among the levels of income investigated.

Table 2 - Distribution of female undergraduates by family income according to the age of first intercourse, use of preservative during the first sexual relation and performing the gynecological care after the beginning of sexual life. Public univerity. Rio de Janeiro, Brazil, 2011.

Variables	Less than 3 m.w.		From 3 to 6 m.w.		More than 6 m.w.		Total		p- va-lue	C*
	f(15)	%	f(48)	%	f(17)	%	f(80)	%		
Age group (years old)									0.277	0.4
Below 14			1	2			1	1.2		
From 14 to 16	8	53.3	13	27.1	6	35.3	27	33.8		
From 17 to 19	6	40	32	66.7	8	47.1	46	57.5		
From 20 to 22	1	6.7	2	4.2	3	17.6	6	7.5		
Sex with preservative									0.589	0.2
Yes	12	80	36	75	11	64.7	59	73.8		
No	3	20	12	25	6	35.3	21	26.2		
Gynecological care									0.59	0.2
Yes	10	66.7	35	72.9	14	82.4	59	73.7		
No	0,5	33.3	13	27.1	3	17.6	21	26.3		

Key: minimum wage (m.w.)
Source: Designed by the authors, 2013.

Table 3 - Distribution of female undergraduates by family income according to type of sexual relationship, use of birth control methods and the place of acquisition of the method. Public university. Rio de Janeiro, Brazil, 2011

Variables	Less than 3 m.w.		From 3 to 6 m.w.		Above 6 m.w.		Total		p-va-lue	C*
	f(15)	%	f(48)	%	f(17)	%	f(80)	%		
Type of sexual relationship									0.563	0.4
Casual partner	1	6.7	3	6.3	3	17.6	7	8.7		
Stable partnet	12	80	34	70.8	12	70.6	58	72.5		
More than one partnet	1	6.7	1	2.1			2	2.5		
Others	1	6.6	10	20.8	2	11.8	13	16.3		
Use of birth control methods									0.761	0.5
None	2	13.3	6	12.5	2	11.7	10	12.5		
Calendar method					1	5.9	1	1.2		
Withdrawal method			2	4.2			2	2.5		
Male preservatives	1	6.7	6	12.5	2	11.8	9	11.3		
Birth control pills	11	73.3	31	64.6	12	70.6	54	67.5		
Day after pills	1	6.7					1	1.2		
Others			3	6.2			3	3.8		
Place of acquisition of the method									0.578	0.4
Health unit	1	6.7					1	1.2		
Drugstore	10	66.7	38	79.2	15	88.2	63	78.8		
Other location	2	13.3	4	8.3			6	7.5		
No answer	2	13.3	6	12.5	2	11.8	10	12.5		

Key: minimum wage (m.w.)
Source: designed by the authors, 2011.

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The most popular birth control method used by the female undergraduates is the birth control pill (67.5%), followed by those who declare they do not practice any birth control method (12.5%), and those who use male protection (11.2%). Most (78.8%) purchase their birth control from the drugstore. There is little variation in the percentage of this data by family income, as we show in Table 3.

When investigating the occurrence of unplanned pregnancies, only one (1.3%) female undergraduate answered positively. This woman had her pregnancy interrupted, however she did not needed further hospitalization.

DISCUSSION

Despite efforts towards democratization and to redress the educational imbalance between ethnic groups in Brazilian society, inequalities still determine access to higher education. Between 1998 and 2008, the gross rate of higher education in the female population of Brazil rose from 12.4% to 39.9% among whites, and from 4.1% to 20% among blacks and browns. Although affirmative policies in higher education, and taking into account the accumulated generation gap, these indicators demonstrate that the increase in female undergraduates with black or brown skin color is still modest[8].

There is a difference in the rates (53.8%) of female undergraduates from public high schools compared to those from other schools. In a profile of freshman undergraduates on Chemistry, Biology and Psychology programs at a public university during 2003 and 2004, only 14.3% were from public high schools[9]. In another investigation, newcomers to the nursing undergraduate program of two universities, one public and one private,

during 2004 and 2005, 46% of students were from the public educational system[10].

Healthcare is a constitutional right in Brazil. The Brazilian Unified Health System (SUS, in Portuguese) is a public policy with a universal characteristic, composed of two subsystems, the public and private, or supplementary network.

Recently, there has been a significant annexation of Brazilian families into the middle class and an increase in the supplementary network subsystem. The number of Brazilians with a health plan reached 49.1 million in 2008, the equivalent to 26.3% of the country's population. In homes where the per capita income is up to a quarter of the minimum wage, only 2.3% have the benefit of a health plan. Among those with income levels above five mw, the percentage of beneficiaries is 82.5%[11].

We identified this tendency of abdication to the right to healthcare by middle class families in order to consume private healthcare plans among the female undergraduates in this study. There was predominance in the use of integrated services of private healthcare plans among those with higher incomes. Despite this, the guarantee to facilitated access to healthcare does not seem to be a direct consequence of this consumption.

Education has an impact on the health-illness process, including sexual and reproductive health. It is known that the more educated the woman, the longer it takes for them to marry, as well as a more frequent use of high efficiency birth control methods and a lower tendency to have unplanned pregnancies[12].

In 2005, the proportion of those between 16 and 19 years old who had already had sexual intercourse was 61.6%, and the average age at which they started their sex life

was 14.9 years old. Among women, this rate was 55.2%, keeping with a tendency seen in previous studies, to opt to start their sexual lives later[13].

We observed this tendency to delay sexual life among the female undergraduates in this study. Research performed among senior undergraduates of a public university found that 46.5% of women had not started their sex lives. Among men, this number was smaller (20.1%). Of those undergraduates with an active sex life, women began their sexual activity at an average age of 17.5 years old, and men at 13 years[14]. We can attribute such differences to the influence of the gender role, which determines different attitudes and practices between men and women.

In a study performed in 2005, 62.5% of females between 16 and 19 years old used contraception during their first sexual intercourse [13]. In this study, we found the proportion to be 73.8%. The use of protection during the first sexual experience is considered a good indicator of continuous use during subsequent sexual relationships [15].

However, the use of protection during the first sexual relationship among female undergraduates does not differ according to family income levels. This finding is different in another investigation, which found a higher frequency of this behavior among youngsters with more education and higher family income[13].

During first sexual relationships there is predominance in the use of male contraception by undergraduates, whereas during later sexual relationships there is an increase in the use of birth control pills, which may indicate the occurrence of more stable relationships [16]. Such findings demonstrate the greater importance attached to preventing unplanned pregnancy over the risk of contracting sexually transmitted diseases (STD) in this type of relationship.

The heterosexual relationships are based on commitment, trust and loyalty, especially for women, who have less power to negotiate the use of contraception with their stable partner.

In this study, we also observed the relationship between the more stable relationships and the increased use of birth control pills. The data regarding on the sexual relationships with a fixed partner and the use of birth control pills showed similarity in all family income levels.

In developed countries there is an association between family income and access to healthcare services. There is evidence of disparities between North-American women with lower socio-economic status and those with higher levels in the care given to family planning. In access to services that provide care, there are inequalities relating to race, ethnicity and socioeconomic levels[17]. In this study, the female undergraduates have access to gynecological care, either from public healthcare services or through the private network.

In Brazil, the attention given to reproductive planning is linked to maternal-child care. In the investigated healthcare services in the state of Rio de Janeiro, women who were forwarded to this service received pre-natal and postpartum care. This same policy-assistive effort did not take into consideration women out of the pregnant-puerperal period or those who had difficulties getting pregnant. This same logic is used to assist adolescents, and professionals provide reproductive care and planning only when the adolescent arrives at the unit searching for pre-natal care[18].

The access to, and quality of reproductive planning care are primordial in guaranteeing

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the social rights of women, and to promote sexual and reproductive autonomy. From this perspective, the low penetration of the individual and curative care model policies created by the Brazilian Ministry of Health has had limited impact, and restricts the possibility of meeting the goals they established.

Besides, the actual liberal economic scenario influences the way healthcare assistance is offered. Female undergraduates acquire their birth control from drugstores, not health units, which may lead to failure in correct usage, and result in unplanned pregnancies.

It is estimated that the annual abortion rate is 2.07 per 100 women between 15 and 49 years old, with women between the ages of 20 and 29 years old making up the largest proportion of this group, with percentages that vary from 51% to 82% of the total. Among adolescents, the total number of abortions in women of reproductive age is between 7% and 9%. The highest numbers of abortions occur in the age group between 17 and 19 years old[19].

Studies of puerperal adolescents show that between 12.7% and 40% of them tried to abort before continuing with the pregnancy, and 25% were pregnant again after one year after aborting. Of those who continued with their pregnancies, 70% dropped out of school[19].

In this study, we identify just one case (1.3%) of unplanned pregnancy, which resulted in abortion without hospitalization. This case is probably not included in official health statistics because it occurred outside of the health system. The investigation of abortion is problematic due to the fact it is a veiled practice in Brazilian society. We require more sensible methodological designs based on the population base to establish its prevalence among female undergraduates, and that guarantee truthful results.

CONCLUSION

The female undergraduates in this study are predominantly single, white, and come from families with net incomes between three or more mw. They initiate their sex lives between the ages of 17 and 19 years, use contraception in their first sexual intercourse, and use the birth control pill as a contraceptive method with a stable partner.

We found a significant difference between the types of healthcare services used in relation to family income. Those with lower family incomes are frequent users of public healthcare services, and those with higher incomes use the private system. The differences in type of health service provider did not influence access to gynecological care after the beginning of their sex lives, the type of sexual relationship adopted and the method of birth control used.

The results of our research provide preliminary evidence that we must consider social and gender determinants in studies of sexual and reproductive health, as should health professionals who work in reproductive planning. Such consideration is necessary due to the expansion of higher education in the country.

This study should also act as an alert to the whole College community as it draws attention to the necessity of promoting educational activities to highlight risk and prevent harm to sexual and reproductive health. Professors and students of nursing have a significant contribution to make in promoting the health of these youngsters through extension activities within the community.

It is important to mention that we cannot generalize the results of this research due to the fact we carried it out using a closed group of individuals in one particular place. There were also limitations related to the

unavailability of data about the age group of the enrolled undergraduates based on the statistical directory.

We require new research to increase the understanding of the topic, to clarify questions not answered by this study, and to improve the production of data regarding sexual and reproductive health in this segment of the population.

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