# Attitudes to premarital counseling among students of Abha Health Sciences College

*Yahia M. Al-Khaldi,* MBBS, ABFM, *Abdullah I. Al-Sharif,* MBBS, FFCM, *Ali A. Sadiq,* MBBS, PhD, *Hany H. Ziady,* MBBS, PhD.

## ABSTRACT

**Objective:** The aim of this study is to explore the attitudes of the students of Health Sciences College in Abha, Kingdom of Saudi Arabia (KSA) towards premarital counseling.

**Methods:** This study was conducted among the students of Health Sciences Colleges in Abha, KSA, during the 2nd semester of the academic year of 1999-2000. A self-administered questionnaire was distributed to all available students who answered it under the direct supervision of the Heads of Departments. The questionnaire consisted of 3 main parts; the first part was regarding socio-demographic and scientific characteristics, the 2nd part concerned with attitudes towards premarital counseling while the 3rd part explored the preferred items to be included in premarital counseling. Data of the questionnaire were entered and analyzed by statistical package for social sciences. Association between categorical variables were tested by Chi-square test and considered significant if (P-value less than 0.05).

**Results:** One hundred and eighty-six students responded, giving a response rate of 70%. Seventy percent of students showed acceptance of premarital counseling while 13% rejected it. Legalization of premarital counseling was agreed on by 19% compared to 41% who refused it. Family history and blood tests for hemoglobinopathies were the most common 2 items preferred to be included in premarital counseling by the respondents.

**Conclusion:** This study showed that most of the students at Health Sciences College in Abha, KSA have good attitudes towards premarital counseling in spite of a few students who justify their refusal by the misunderstanding of Islamic rules. This misunderstanding needs intensification of health education in which religious leaders are involved to clarify and correct this misconception.

**Keywords:** Premarital counseling, health science college, students.

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Genetic disorders and multi-factorial health problems such as diabetes, obesity, bronchial asthma are common in the Saudi community.[1-9] One of the most contributing factors of high prevalence and incidence of these health problems is consanguinity, which was found to be 50% in the Kingdom of Saudi Arabia (KSA).[10-13] To reduce these problems and their impact on the social, emotional psychological and cost dimensions of the family and the health system in KSA, it is essential to practice premarital counseling (PMC) which was successful in some Western and Arab countries.[14-16] In a country such as KSA where the consanguinity is high and where marriages among cousins are traditional in many regions, it could be difficult to accept PMC. In one study carried out in Riyadh, KSA it was found

From the Department of Academic Affairs, Health Sciences College for Boys, (Al-Khaldi), Abha, General Directorate of Hospitals, (Al-Sharif), Ministry of Health, Riyadh, *Kingdom of Saudi Arabia*. Department of Community Medicine, (Sadiq, Ziady), Alexandria University, *Egypt*.

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Address correspondence and reprint request to: Dr. Yahia M. Al-Khaldi, PO Box 2653, Abha, *Kingdom of Saudi Arabia*. Tel./Fax. +966 (7) 2271666. E-mail: yahiammh@hotmail.com

that acceptance of PMC was encouraging.[17] Students of Health Sciences Colleges (HSC) who will graduate within few years are in a good position to play a major role in propagating the importance of PMC and educating their families regarding its practical application in the case of knowing their attitudes towards PMC.

The aim of this study is to explore the attitudes of the students studying at HSC in Abha, Southwest of KSA regarding PMC.

**Methods.** This study was carried out during the 2nd semester of the academic year 1999-2000 among the students of HSC of boys in Abha, the capital city of Aseer region in the Southwest of KSA. The investigators designed a questionnaire, which consisted of 3 main parts: The first part concerned with the socio-demographic data such as age, marital status, educational level and residency. The 2nd part consisted of 8 items which dealt with the attitude towards PMC and the expected response to it in the case of its positive results. The 3rd part which consisted of 14 items was regarding the subjects that they preferred to be included in a Premarital Counseling Program (PMCP). The questions, which concerned with attitudes were graded by using Likert scale which consists of 5 points. The first point means strongly agreed while the 5th point means strongly disagreed. Heads of the 6 diferent departments distributed the questionnaire to all the available students of the college and directly supervised the questionnaire answering.

Data of the questionnaire were entered and analyzed by using Statistical Package of Social Science (SPSS).

**Results.** The total number of the students at the beginning of the academic year of 1999-2000 was 268 students. Fifty-six students graduated in the end of the first semester, 26 students were absent and 186 students responded to this questionnaire giving a response rate of 70%. The characteristics of the students under this study are in **Table 1**. Ninty percent are singles, 47% live in villages and 10% have family history of genetic diseases. Attitudes towards PMC are summarized in **Table 2**. Premarital counseling was accepted by 70% while 17% were neutral and 13% refused PMC. Those accepted PMC justified their acceptance by avoiding transmission of diseases. Majority of those who did not accept it believed that PMC inteferes with God's will. When we enquired with regards to (what will you do if the fiancée insisted for PMC?), the acceptance rate raised to 81%. On the other hand, 20% thought that marriage will not continue if they insist their fiancée encounters PMC. Agreement on having PMC as an obligatory premarital procedure was accepted by 29%, 23% were neutral, 29% disagreed while 19% did not respond to this question. Reaction to positive PMC results showed that 27% will terminate engagement, 42% will continue marriage for different reasons, 20% will decide depending on the probability of getting or transmitting the diseases and 9% did not know what they will do. Agreement on the issue of PMC legislation was accepted by 19% and refused by 41%.

**Table 1 -** Socio-demographic characteristics of students under the current study.

| **Characteristics n=186**<br>**Age (Year)** | **21 ± 2.3**<br>**n (%)** |
|---|---|
| ***Marital status*** | |
| Single | 168 (90) |
| Married | 11 (6) |
| Engaged | 7 (4) |
| ***Place of residency*** | |
| City | 68 (37) |
| Village | 87 (47) |
| Baduian | 15 (8) |
| Missing | 16 (9) |
| ***Department*** | |
| Foundation | 74 (40) |
| Nursing | 22 (12) |
| Anesthesia | 18 (10) |
| Pharmacy | 20 (11) |
| Dental | 29 (15) |
| Laboratory | 23 (12) |
| ***Educational level*** | |
| First year (foundation) | 74 (40) |
| 2nd year | 55 (30) |
| 3rd year | 57 (30) |
| ***Family history of genetic diseases*** | |
| Positive | 19 (10) |
| Negative | 167 (90) |

n - number

Statistical analysis did not show any association between attitudes and socio-demographic characteristics of the students such as marital status, residency place or scientific variables such as specialty or educational level ($P>0.05$). **Table 3** shows the items, which were preferred by the participants to be included in the PMC. Family history was preferred by more than three-quarters, test for hemoglobinopathies was preferred by more than two-thirds, test for Acquired Immuno-deficiency syndrome (AIDS), knowing the physiology of sex and probability of having genetic disorders was mentioned by 53%, 52% and 50%.

Statistical analysis to find out association between the socio-demographic-scientific profile of the participants and the items of PMC revealed that the higher level of education and those who live in cities compared to those studying in the foundation year or live in villages preferred more items to be included in

**Table 2 -** Attitudes of the students under the study towards premarital counseling.

| Attitudes | n (%) |
|---|---|
| ***Acceptance premarital counseling*** | |
| Strongly agree | 61 (33) |
| Agree | 68 (37) |
| Neutral | 31 (17) |
| Disagree | 17 (9) |
| Strongly disagree | 9 (4) |
| ***Reason for agreement to carry out premarital counseling*** | |
| To prevent transmission to my offspring | |
| To avoid transmission of diseases to me | 109 (59) |
| To ensure that the person that I want to marry is healthy | 70 (38) |
| To ensuring fitness for marriage | 58 (31) |
| | 50 (27) |
| ***Reason for disagreement to premarital counseling*** | |
| Do not want to interfere with God's will | 18 (10) |
| Afraid that the test results will not be in the favor of my choice | 9 (5) |
| Afraid that the positive results will prevent continuation of marriage | 7 (4) |
| Family will refuse continuation of marriage | 7 (4) |
| Feeling that such a test result is an insult or affront to me | 4 (2) |
| ***Response to carry out premarital counseling if your fianceé asks you to do it*** | |
| Strongly agree | 82 (44) |
| Agree | 69 (37) |
| Neutral | 17 (9) |
| Disagree | 11 (5) |
| Strongly disagree | 7 (3) |
| ***Thinking about termination of marriage in the case of asking for premarital counseling by your fianceé*** | |
| Yes | 36 (19.4) |
| No | 76 (41) |
| Do not know | 74 (39) |
| ***Agreement on making premarital counseling as an obligatory procedure before marriage*** | |
| Strongly agree | 14 (8) |
| Agree | 39 (21) |
| Neutral | 43 (23) |
| Disagree | 45 (24) |
| Strongly disagree | 10 (5) |
| No response | 35 (19) |
| ***Agreement on regulations which prevent marriage in the case of positive premarital counseling*** | |
| Strongly acceptance | 13 (7) |
| Agree | 22 (12) |
| Neutral | 39 (21) |
| Disagree | 53 (29) |
| Strongly disagree | 22 (12) |
| No response | 37 (20) |
| ***Response to premarital counseling if you were told that you will have affected children if you marry*** | |
| Continue engagement and marriage becasue I believe in God | 59 (32) |
| Discontinue engagement | 51 (27) |
| Decision will depend on the probability of getting the disease | 38 (20) |
| I don't know what to do | 17 (9) |
| Continue engagement and marriage due to emotional and affected reasons | 15 (8) |
| Continue engagement and marriage due to family pressure | 4 (2) |

n - number

PMC (P<0.01). On the other hand, when we analyze the association between specialties and items preferred to be included in PMC, we found that students of Dental Department preferred to include personal history and health education regarding sexually transmitted diseases (STD's) more than ttheir counterparts in the opther departments (P<.0.01) while the students of Laboratory Department preferred testing for hemoglobinopathies more than the others. (P< 0.01).

**Discussion.** In spite of the importance of PMC in KSA, this study is one of the few studies, which explored this subject among Saudi citizens.[17] In this study, 70% of the participants accepted PMC. This figure is similar to that reported from Riyadh, KSA[17] but higher than that reported from Egypt by Eshra et al[18] in 1989. Those who accepted PMC justified their acceptance by many reasons; to avoid transmission or having the diseases which indicates their

**Table 3 -** The preferred items of premarital counseling by the students under the study.

| Items | n (%) |
|---|---|
| ***History*** | |
| Family history of genetic disorders | 146 (78.7) |
| Personal medical history | 74 (40) |
| Personal information (age, job, educational status) | 62 (33) |
| ***Physical exam and investigations*** | |
| Blood test for hemoglobinopathy | 124 (67) |
| HIV | 98 (53) |
| Hepatitis-B | 81 (44) |
| Complete physical examination | 76 (41) |
| VDRL | 74 (41) |
| Rubella serology | 65 (35) |
| ***Health education subjects*** | |
| Physiology of sex | 97 (52) |
| Genetic diseases | 93 (50) |
| Sexually transmitted diseases | 82 (44) |
| Vaccination against rubella | 71 (38) |
| Contraceptive methods | 58 (31) |

n - number, HIV - human immuno-deficiency syndrome
VDRL - venereal disease research laboratory test

understanding of the aim of the PMC and few of them refused it because of their misunderstanding of the Islamic rules. The reasons for rejection of PMC were either related to misunderstanding of the Islamic Religion or the PMC results will not be in the favor of continuation of the marriage process. The misconception regarding Islam is necessary to be corrected by the religious leaders as recommended by the previous study.[17] The percentage of acceptance of the participants to do PMC increased to 81% if the fiancée requested to have it carried out. On the other hand, 19.4% thought that marriage will not continue if the fiancée asked her fiancé to carry out PMC. This low attitude towards PMC could be positively changed towards the favor of PMC through practicing PMC as noticed by Abdel-Meguid et al[19] who found that establishing a genetic clinic tended to increase the number of couples who asked for genetic counseling. Making PMC as an obligatory procedure was welcomed by less than one-third, while issuing regulations against continuation of marriage in the case of positive PMC results was accepted by less than one-fifth. These figures are lower than that reported by Al-Kahtani.[17] This negative attitude towards legislation of PMC is in need of intensive health education particularly for those with a high risk of transmission of genetic disorders.

Reactions of the participants to positive PMC results were different. About one-quarter said that they will discontinue engagement while 42% will continue for different reasons and 9% did not know what to do. Twenty percent mentioned that their decision will depend on the probability of getting the disease. Generally, the negative reaction to positive PMC results in spite of the reasons could be eliminated by explaining the importance and advantages of PMC and by the establishment of good patient-doctor relationship. Selection of components of PMC should depend on and consider the profile of the community in which PMC will be conducted. In a region such as Aseer, KSA, family and personal histories are very essential due to high rate of consanguinity. Obtaining such data will help to classify the individuals to high or low risky groups. Classification of the individuals to these 2 groups will be helpful to manage the resources and avoid misuses of the laboratory tests. Carrying out different laboratory tests were preferred by 67% for testing for hemoglobinopathies, 53% for human immuno-deficiency virus, 44% for hepatitis serology, 40% for Venereal diseases research laboratory and 35% for rubella serology. Different responses to these different tests could be multi-factorial. Personal, social, cultural factors, attitudes and behaviors of the participants could play important roles in such preference. However, selection of any test should be based on the grade of risk of the individual to have such health problems. Health education is the corner stone of counseling which must be directed to the needs of the counselee. More than 40% of the participants in this study reported that they preferred to have health education regarding physiology of sex (52%), genetic diseases (50%), sexually transmitted diseases (44%) and contraceptive methods (31%). A study conducted among the secondary school Saudi students in Al-Qassim region, KSA revealed that the knowledge with regards to AIDS improved after a health education program[20] while a study conducted in India found that 97% of the students showed positive attitudes towards health education regarding sex physiology and 26.7% of them mentioned that there is a need for such subject in order to prevent STDs.[21] In Egypt, Soliman[22] found that conducting counseling among couples improved their knowledge, practice and decision making regarding family planing. Generally, health education on these subjects should be given a priority among adolescents in order to change their attitudes and behaviors particularly before engagement.

Health Sciences Colleges from which hundreds of students graduate annually should be educated with regards to the importance, elements and conducting of PMC as those highly educated individuals can educate and practice PMC in their community.

Statistical analysis revealed that there was a strong association between the preferred sites of PMC and the educational level, specialty and place of residency. However, we could not find any association between characteristics and attitudes

towards PMC). These important findings indicate that knowledge could be improved with educational level and urbanization and affected by specialty while attitudes are difficult to be changed.

In conclusion, this study showed that most of the students of HSC in Abha, KSA have positive attitudes towards PMC. Few of them showed negative attitudes due to religious misunderstanding. These negative attitudes could be changed through intensive religious health education by the religious leaders and by making PMC as a part of the HSC curriculum in addition to establishment of PMC programs at Primary Health Care Centers. A country wide study is suggested in order to get a clear picture regarding such an important issue.

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