

ORIGINAL ARTICLE**Barriers to Contraceptive Uptake among Women of Reproductive Age in a Semi-Urban Community of Ekiti State, Southwest Nigeria****Kabir A. Durowade^{1*}, Lukman O. Omokanye², Olusegun E. Elegbede¹, Stella Adetokunbo¹, Charles O. Olomofe¹, Akinyosoye D. Ajiboye², Makinde A. Adeniyi¹, Taofik A. Sanni¹****OPEN ACCESS**

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ABSTRACT

BACKGROUND: Globally, unplanned pregnancy and sexually transmitted infections (STIs) persist as a significant threat to women's reproductive health. In Nigeria, despite huge resources committed to family planning programs by stakeholders, contraceptive use has been very low. This study aimed at unraveling the barriers to the use of modern contraceptives among women of reproductive age (15-49 years) in Ise-Ekiti community, Ekiti State, Southwest Nigeria.

METHODS: This study was a cross sectional study among women aged 15-49 years. A multi-stage sampling technique was used in the recruitment of respondents from the community. An interviewer-administered questionnaire was used to collect data. Data were analyzed using SPSS version 15.

RESULTS: Although contraceptive awareness among respondents was high 496(98.6%), only 254 of the 503 respondents were using modern contraceptive methods giving a Contraceptive Prevalence Rate (CPR) of 50.5%. Among those not using any form of contraceptives, some identifiable barriers to contraceptive use includes desire for more children, 62(39.5%), partner disapproval, 40(25.5%), and fear of side-effects, 23(14.6%). Factors associated with contraceptive uptake include marital status ($p=0.028$), educational level ($p=0.041$) and religion ($p=0.043$) with traditional worshippers having the least uptake.

CONCLUSION: This study showed that awareness to modern forms of contraceptives does translate into use. The identified barriers to contraceptive uptake suggest the need to improve uptake of contraceptives through a community-based and culturally acceptable intervention as doing this will go a long way in addressing some of these barriers.

KEYWORD: Contraceptives uptake, barriers, women of reproductive age

INTRODUCTION

Contraceptive methods are preventive methods which help women avoid unwanted pregnancies (1). They include all temporary and permanent measures to prevent pregnancy resulting from coitus (1). Although family planning is not synonymous with birth control, planning, provision and use of birth control are called family planning methods (1). Some contraceptives prevent against sexually transmitted infections (STI). Within the same society, contraception varies amongst people of different socio-cultural, educational, religious or occupational affiliations (2). Family planning was cited as essential to the achievement of the erstwhile millennium development goals (MDG) because it has a direct impact on women's health and consequences on each pregnancy (3). It is believed that high fertility dis-empowers women (4). Globally, unplanned pregnancies and STI persist as significant threats to women's reproductive health (5).

The level of awareness to contraceptive varies from place to place. Among Nigerian bankers aged 21-45 years, it showed that about a 100% of them are aware of at least one method of contraception (2). A similar study in Osogbo, Nigeria put the awareness of modern contraceptives to be 90.3% among respondents with a mean age of 28.6 ± 6.65 years (6). A study among Ethiopian adults showed a high knowledge of contraceptives among respondents (7).

Studies in Africa identified barriers like the fear of side-effects (44.0%), ignorance (32.0%), misinformation (25.1%), superstition (22.0%) and culture (20.3%) (6). Other studies identified poor spousal contraceptive communications (4), financial constraints and regional barriers and lack of access to services. Similar studies around the world identified poor health services, poor knowledge of methods (3) and provider-related barriers to its provision (8). This study aimed to determine the awareness, knowledge and barriers to contraceptive uptake among adults in Ise-Ekiti, Ekiti state, Southwest Nigeria.

METHODS

Ise-Ekiti, headquarter of Ise/Orun Local Government Area (LGA) of Ekiti State, is located

in the Southwestern part of Nigeria. The community is located within the tropics and geographically positioned near the equator. With an annual growth rate of 3.2%, the projected population of Ise-Ekiti is 254,350. Ise/Orun LGA has 10 wards of which eight are in Ise-Ekiti and are numbered 1-8. The remaining two wards are in Orun. The people of Ise-Ekiti speak the Ekiti dialect of the Yoruba language and are predominantly farmers. However, few people are engage in vocational services. Most people practice Christianity and Islam while some are traditional worshippers.

Grand multi-parity and high teenage pregnancies are a common sight. They also account for the high maternal morbidity and mortality during pregnancy, delivery and puerperium. There is also a high rate of neonatal and infant mortality. Worse still, access to family commodities is poor in the community.

This study was a descriptive/cross sectional study to identify barriers to contraceptive uptake among adults in Ise-Ekiti, Ise/Orun Local Government Area, Ekiti State. The minimum sample size was determined using Fisher's formula ($n = Z^2 pq/d^2$) for estimating sample size where the population is greater than 10,000 (10,11). A sample size of 345 was used for the study. A multistage sampling technique with four stages was used to select the respondents for the study.

Stage 1: Simple random sampling technique by balloting was used to select four wards out of the eight wards in Ise-Ekiti.

Stage 2: Simple random sampling technique by balloting was used to select two communities each from the selected four wards. Consequently, a total of eight communities were selected.

Stage 3: The communities were delineated into Enumeration Areas (EAs) with each comprising 44 households. Cluster sampling technique was used to select respondents in the enumeration areas. Households in the EAs were visited. Each EA was regarded as a cluster, all eligible and willing respondents were recruited into the study. Consequently, as a result of the use of cluster sampling technique, a correction factor of 1.2 was used to increase the computed sample size. This gave a sample size of 414. However, a total of 503

subjects were interviewed as eligible, and willing respondents were selected in each household.

Interviewer-administered, semi-structured questionnaire was used to elicit the study subjects' socio-demographics, awareness, knowledge and barriers to contraceptive uptake among the respondents. The questionnaire was pre-tested in Orun community, another community in Ise/Orun Local Government Area of Ekiti State, which is about 60 kilometers from Ise-Ekiti. This was done to detect deficiencies or ambiguities in the questionnaire and making appropriate correction. Four research assistants also participated in the study. They were resident doctors trained on data collection using interviewer-administered questionnaire. Data collation and editing were done manually to detect omission and ensure uniform coding.

The analysis was done using SPSS version 15; frequency tables and cross-tabulations were generated to show the association between the socio-demographic variables and barriers to uptake of contraceptives among the respondents. Univariate and Bivariate analyses were employed to analyze the data. Chi-square test was used to determine statistical significance of observed differences in the cross-tabulated variables.

Ethical approval for the study was obtained from the Research and Ethical Committee of the Federal Teaching Hospital, Ido-Ekiti. Informed consent was obtained from the participants after the nature of the research was explained to them. Anonymity and confidentiality of the respondents' responses were ensured and guaranteed.

RESULTS

The total number of women interviewed was 503, and as shown in Table 1, a total of 411(81.7%) were married and others were single, 81(16.1%), divorced, 7(1.4%), and separated, 4(0.8%). Also as seen in Table 1, the levels of education of the women were no formal education, 22 (4.4%), primary, 84 (16.7%), secondary, 239 (47.5%) and tertiary, 158 (31.4%). As shown in Table 2, 496 (98.6%) respondents had ever heard contraceptive before, while only 7 (1.4%) had not. The common contraceptives ever heard about by the women include male condom, natural methods, pills and injectables, IUCD with 491 (99%), 457 (92.1%), 449 (90.5%), 426 (85.9%) and 275 (55.4%), respectively.

In Table 3, the number of women that said family planning commodities were readily available were 381 (71.5%) but 122 (24.3%) insist commodities were not readily available. Those that considered the family planning services out of reach suggest; health education 61 (50%), improved supplies 35 (28.1%) and reduction in prices 26 (21.3%) as possible ways to increase availability of the commodities.

As shown in Table 4, 346 (68.8%) women had ever used one form of contraceptive while 157 (31.2%) had never used any form of family planning. Also in Table 4, duration of use among those who had used contraceptives was less than 1 year, 82 (23.7%), 1-2 years, 124 (35.8%), 3-5 years, 87 (25.2%) and above 5 years, 53 (15.3%). Their reasons for using contraceptives were prevention of unwanted pregnancy, 276 (79.8%), suitability and reliability of methods, 192 (55.5%), accessibility, 170 (49.1%), affordability, 106(30.6%) and little or no side effect, 63 (18.2%).

As presented in Table 5, respondents' marital status ($p=0.028$), religion ($p= 0.043$) and level of education ($p=0.041$) were found to be significantly associated with uptake of contraception.

Table 1: Socio-demographic Characteristics of respondents

Variable	Frequency N = 503	Percentage
Age		
Less than 20	71	14.1
20 – 24	82	16.4
25 – 29	112	22.2
30 – 34	101	20.1
35 and above	137	27.2
Marital Status		
Single	81	16.1
Married	411	81.7
Divorced/ Separated	7	1.4
Widowed	4	0.8
Religion		
Christianity	358	71.2
Islam	136	27.0
Traditional	9	1.8
Ethnicity		
Yoruba	488	97.0
Non Yoruba	15	3.0
Level of Education		
No formal education	22	4.4
Primary	84	16.7
Secondary	239	47.5
Tertiary	158	31.4
Occupation		
Civil Servant	171	34.0
Self employed	242	48.1
Student	84	16.7
Unemployed	6	1.2

Table 2: Awareness of Contraception among respondents

Variable	Frequency N = 503	Percentage
Ever heard of contraception		
Yes	496	98.6
No	7	1.4
Sources of information* (n = 496)		
Health worker	356	71.8
Friend/ Relative	248	50.0
Mass media (radio, TV, Newspaper etc)	215	43.4
School	148	29.8
Neighbour	52	10.5
Methods ever heard of* (n = 496)		
Male condom	491	99.0
Natural	457	92.1
Pills	449	90.5
Injectibles	426	85.9
IUCD	275	55.4
Female condom	55	11.1
Traditional	51	10.3

*Multiple responses

Table 3: Availability of contraceptive commodities

Variable	Frequency N = 503	Percentage
FP commodities readily available?		
Yes	381	75.7
No	122	24.3
How to improve the availability (n = 122)		
Health education (to improve utilization)	61	50.0
Improved supply/access	35	28.7
Govt should reduce price	26	21.3

Table 4: Contraceptive uptake and its identified barriers among the respondents

Variable	Frequency N = 503	Percentage
Using any form of contraception		
Yes	346	68.8
No	157	31.2
What form of contraception (n =346)		
Modern methods	254	73.4
Natural methods	90	26.0
Traditional methods	2	0.6
How long in years (n =346)		
Less than 1	82	23.7
1 – 2	124	35.8
3 – 5	87	25.2
Above 5	53	15.3
Reasons for using FP (n =346)		
Prevent unwanted pregnancy	276	79.8
Suitable and reliable	192	55.5
Accessible	170	49.1
Affordable	106	30.6
Little or no side effects	63	18.2
Reasons for not using FP (n =157)		
No reason	71	45.2
Desirous of more children	62	39.5
Husband's disapproval	40	25.5
Side effects	23	14.6
Against my culture	11	7.0
Not aware	7	4.5

Table 5: Relationship between socio-demographic characteristics and contraceptive uptake

Variable	Using any form of contraception		Total	χ^2	p – value
	Yes (%) n = 346	No (%) n = 157			
Age				2.9	0.564
Less than 20	48 (67.6)	23 (32.4)	71(100.0)		
20 – 24	56 (68.3)	26 (31.7)	82(100.0)		
25 – 29	83 (74.1)	29 (25.9)	112(100.0)		
30 – 34	71 (70.3)	30 (29.7)	101(100.0)		
35 and above	88 (64.2)	49 (35.8)	137(100.0)		
Marital Status				9.1	0.028
Single	54 (66.7)	27 (33.3)	81(100.0)		
Married	286 (69.6)	125 (30.4)	411(100.0)		
Divorced/ Separated	5 (71.4)	2 (28.6)	7(100.0)		
Widowed	0 (0.0)	4 (100.0)	4(100.0)		
Religion				6.3	0.043
Christianity	253 (70.7)	105 (29.3)	358(100.0)		
Islam	90 (66.2)	46 (33.8)	136(100.0)		
Traditional	3 (33.3)	6 (66.7)	9(100.0)		
Ethnicity				0.6	0.572*
Yoruba	337 (69.1)	151 (30.9)	488(100.0)		
Non Yoruba	9 (60.0)	6 (40.0)	15(100.0)		
Level of Education				8.3	0.041
No formal education	10 (45.5)	12 (54.5)	22(100.0)		
Primary	53 (63.1)	31 (36.9)	84(100.0)		
Secondary	164 (68.6)	75 (31.4)	239(100.0)		
Tertiary	116 (73.4)	42 (26.6)	158(100.0)		
Occupation				2.4	0.497
Civil Servant	121 (70.8)	50 (29.2)	171(100.0)		
Self employed	159 (65.7)	83 (34.4)	242(100.0)		
Student	62 (74.1)	22 (25.9)	84(100.0)		
Unemployed	4 (66.7)	2 (33.3)	6(100.0)		

*Fisher exact test

DISCUSSION

This study shows average utilization of modern methods of contraception despite a near total awareness of family planning and contraception. The majority (98.6%) of the clients knew at least one form of contraception. This is similar to findings in other studies carried out within and outside of the country (9). The knowledge of various modern methods were very high except for the female condom which was low (11.1%).

The group of women who had no reason for not using any contraception was surprisingly the

highest. This accounted for 45.2% of those using contraceptives. This may be due to misconceptions that are yet unresolved in the minds of the respondents (10). It could also be that the women may consider their reasons too private to be discussed with anyone, which is common among teenagers and unmarried women (12). The group of women who desired more children was 39.5% and this can be explained by the prevailing mindset of people living in Sub-Saharan Africa about child-bearing. This includes desire for a large family size, desire for a specific number of children of a particular gender and sense of

accomplishment that is derived from having many children (13,14). Lack of spousal support for utilizing contraception also featured strongly. The typical woman in Sub-Saharan Africa still relies on the husband for key decision making including healthcare. This is because she may not be empowered economically to take such decisions by herself despite concerted efforts by the World Health organization and United Nations (16). The fear of side-effects of contraceptive use did not rank high in our study unlike findings in similar studies in Kenya, where such concerns ranked second. However, the fears that many women raised include fear of menstrual irregularities, delay in return to fertility, weight gain, congenitally malformed babies and inability to breastfeed babies when they are born (16-18).

The findings that utilization was higher among Christians than those practicing Islam show the effect of religion on contraceptive use. This has been found in similar studies (16,19). Utilization was also found to be higher among those with formal education than those without any education. It is higher among those with primary level of education and the self-employed and civil-servants unlike those with no employment. Social class and education were found to correlate positively with contraceptive uptake in similar studies (12,20,21).

This study, unlike many studies from other regions, did not show some other reasons for contraceptive non-use which include lack of sexual intercourse or infrequent sexual intercourse which was seen in women interviewed in Nepal and Bangladesh. The inability to volunteer such information may stem from the fact that discussions about sex is considered private.

Our findings show that a lot of women get information about contraception from health workers. However, half of these women equally obtain the information from friends and relations. This source of information may involve dissemination of a lot of misconceptions, which will not guide appropriate decision-making regarding family planning.

The implication of the findings is that much advocacy on use of modern methods of family planning. Family planning serves as a way of improving the socio-economic well-being of any

society and is also pivotal in reducing the incidence of abortions and its complications.

There is a need to unravel why women refuse contraception for no reason. When such reasons are known, the women can be helped much better. As it is seen in this study, the awareness of modern family planning methods does not translate into use. There are a lot of obstacles to the use stemming from misconceptions. The campaigns for family planning services should aim at the misconceptions in order to drive the demand and remove the barriers. The influence of the male partner should also be considered, and more male friendly services should be incorporated into the practice of family planning.

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