

FACTORS INFLUENCING CONTRACEPTIVES USE AMONG GRANDMULTIPARA IN ILE-IFE, NIGERIA

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ABSTRACT

Objective: To determine modifiable factors that influence contraceptive usage among grandmultiparas in a South-Western Nigerian setting.

Methodology: A prospective survey was done among antenatal attendees in OAUTHC from January to December 2006.

Using interviewer administered semi-structured questionnaire data were collected from all grandmultiparous attendees on sociodemographic characteristics, contraceptive awareness and usage, contraceptive intentions and the role of men on contraceptives usage. Data were analysed with SPSS 11.0 and result presented in descriptive statistics.

Results: The prevalence of grandmultiparity was 9.04% in the studied population, and their mean age was 36.73 ± 4.7 years: Eighty-one percent attended secondary school, and 65% were monogamous. Despite high level of awareness (51.6-100%) contraceptive usage was low (5.9 to 40.8%).

About 90% agreed that family planning improve quality of family life. While 80% had no intention for further childbearing only 36% intended to use BTL. Sex preference was the only motivation for further childbearing in all (100%) of them.

Conclusion: High literacy rate in this group did not impart positively in reducing the unmet need. Increased awareness on permanent contraception and the role of men need to be promoted. Health education that will break the negative strongholds of cultural factors has to be introduced gradually at the primary school levels.

Keywords: Contraceptive usage, Grandmultiparity, Cultural factors.

INTRODUCTION

In the last 5 decades, contraception usage had risen from the poor level of 10% to 60% in many parts of the developing world. Despite this improvement some areas like Sub-Saharan Africa still have lower rate of usage and high rate of grandmultiparity within the population¹. In recent estimate in the world today, there are 120 million couples with unmet need out of the estimated one billion of the reproductive age². If this gap of unmet need is closed according to UNFPA/AG1 analysis about 1,5million lives would be saved every year including 505,000 maternal deaths. It is therefore crucial to the success of any family planning program to find

out factors that promote grandmultiparity in these societies in order to be able to design a tailored intervention for those in reproductive age.

Grand multiparity refers to carrying more than four pregnancies beyond 28 weeks of gestation. This term rarely applies these days of limitation of family size in the Western World but it has

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persistently remained a feature of Obstetric practice in the developing countries. In the Industrialised countries, where socio economic conditions are very good, literacy rates are high and there is good access to high quality health care services, the risk associated with high parity may not be as pronounced as is observed in Sub-Sahara Africa³. Here, grandmultiparity goes hand in hand with extreme poverty and deprivation, early marriage and early childbearing. Other socio-cultural correlates of grandmultiparity include the phenomenon of child labour, old age support for adults by children, intense social pressure to bear male offsprings, competition among wives in polygamous setting to bear children, low status of women and poor level of education. In addition to these, the patriarchal orientation of families determines the concept of family size held by women⁴.

A number of major obstetric complications which are of themselves independent high risk factors occur with higher frequency in grand multipara, these include: multiple pregnancy, antepartum haemorrhage, malpresentation, unstable lie postpartum haemorrhage and uterine rupture^{5,6,7}.

With these backgrounds of diverse obstetric problems associated with grandmultiparity the logical consequences are increased maternal mortality and perinatal mortality^{8, 9, 10}. The operative delivery and infant mortality rates are also high.

The use of family planning and contraception will go a long way in reducing maternal death through better child spacing and moderate family size. Reduction in the incidence of grandmultiparity in an environment will greatly reduce the incidence of obstetric haemorrhages in all its forms, and thereby cause a decline in a major cause of maternal mortality in Africa¹¹. High prevalence of contraceptive usage will go a long way to reduce maternal deaths through reduction in the incidence of complication of unsafe abortion and good child-spacing culture and having a desired family size¹². Apart from this, child spacing and reduced family size can also help in breaking the vicious cycle of poverty, deprivation and poor indices of maternal and child health. Better child survival goes hand in hand with improved family planning culture.

Men's reproductive motivation to a great extent, have been found to influence reproductive

behaviour of their wives and it is therefore an important factor in addressing the problem of unregulated family size, poor child spacing and grandmultiparity¹³.

The objective of our study is to determine the incidence of grandmultiparity among the mothers attending the antenatal clinic of a tertiary hospital unit; ascertain their contraceptive knowledge and practices; and identify cultural beliefs and attitudes that influence their contraceptive practices. The information obtained could be used in designing programmes that will promote contraceptive usage among these high risk groups. This will ultimately lead to improved maternal and child health, and reduction in a maternal mortality in this environment.

MATERIALS AND METHODS

This study was carried out among the antenatal clinic (ANC) attendees in the Ile-Ife unit of the Obafemi Awolowo University Teaching Hospitals Complex (O.A.U.T.H.C.), Ile-Ife, Nigeria over a 12 month period (January to December 2006). O.A.U.T.H.C. is a tertiary health institution serving as a referral central for five (5) contiguous states out of the federation. The Ile-Ife hospital unit receives about half of the maternity cases coming to the institution.

The data were collected with the aid of an interviewer-administered semi-structured questionnaires applied to all grandmultipara who came to register at the booking clinic within the study period. The inclusion criteria were women who had carried more than four pregnancies beyond 28 weeks of gestation (inclusive of the index pregnancy) regardless of the outcomes.

The interviews were conducted by two trained personnel who could converse both in English and Yoruba (the local dialect) fluently. The instrument had been pretested at the same clinic in December 2005 on 20 pregnant women to remove ambiguity and ensure content validity of the instrument.

The research instrument has 3 sections: the first section elicited information on sociodemographic data, the second section on the knowledge, usage and attitude to usage of contraception, while the third section asked questions on contraceptive intentions, desire for further child-bearing, determinants of

contraceptive practices and the role of men on the use of contraception.

The data were analyzed with the use of statistical package for social sciences (SPSS) software, Version 11.0. The results were summarized using descriptive statistics.

RESULTS

In the year 2006, 1,007 mothers booked at the Ife maternal, unit of O.A.U.T.H.C., 91 of these were grandmultiparous giving an incidence of 9.04%. The age ranged between 24 to 50 years with a mean of 36.73 ± 4.69 years. The modal parity was 5 (37.3%) but most (82%) of the clients were between para 5 and 7. Table 1 shows that 74(81.3%) of the clients had a minimum of secondary school education and they were all married. Sixty-five percent were in monogamous relationship while the rest were in polygamous relationship.

Table 2 shows the knowledge and usage of contraception among the respondents: All the respondents had knowledge about lactational amenorrhoea. Among the modern methods they knew about condom (93.4%) more than any other methods while they had the least knowledge (51.6%) about male sterilisation. Four out of five women knew about bilateral tubal ligation. Condom was also the most ever used (38.5%) method of modern contraception among the study population.

Table 3 shows the cultural beliefs and attitudes towards the use of modern contraception. Most women (89.0%) agreed that couples who practise FP have better quality of life than those who do not and 95.6% confirm that FP help parents to take better care of the children. About one third of the respondents felt that husband should be the one to decide on FP, method and 85.7% believed that modern contraceptives are safe. Only 3(3.3%) respondents agreed that women should continue to bear children until she has a son.

Table 4 shows information about paternal factors, contraceptive intentions and fertility needs of the respondents. It implied that almost 30% of the respondents did not discuss the latest contraception with their husbands, 35% did not receive encouragement from their spouses and also only 72.5% received the husbands' approval.

Almost four out of five had no intention for further childbearing, and 11.0% were undecided. Among the 9(9.9%) who still wanted children, two-third of them wanted at least a son. The number of grandmultipara who intended future use of contraception was 70(77.0%) and this almost tallied with the number of those who had decided against bearing more children but then, less than half 33(36.3%) of the group intended to use bilateral tubal ligation (a permanent method) as a means of contraception. About a quarter of the clients could not make a concrete decision whether to use contraceptive or not after the delivery of the index pregnancy.

DISCUSSION

This study has revealed that the grandmultiparity is still a common feature of Obstetric practice in this environment. Our rate of 9.1% is one of the highest recorded in the country it is almost twice as higher than the findings from study done in Lagos^{14,15} Ondo but comparable to that of Ibadan city few years ago⁹ but less than that of Enugu⁶ all being large cities in Nigeria. However, these figures are all much higher than in Karachi, in Parkistan⁵.

The contraceptive usage of the available modern methods was low (3.3% for Norplant and 38.5% for condoms) in the study population and this is definitely an important factor in the high prevalence of grandmultiparity in the environment. An unmet need of 59.4% had been found in a previous work done for a cross section of women in reproductive age in the same environment¹⁶ and the findings in this selected group support the fact that the unmet need is higher among the grandmultipara compared to the average for all women in the same population. The contraceptive usage is however much higher than 7.8% found by Kuti in Ondo, Nigeria¹⁵ among the lower socio-economic people within the same tribe, 81.5% of his series either had no formal education or education below primary as against the sharp contrast in this study where 81.3% had at least secondary school education. This disparity may lend credence to the fact that education is a positive factor in improving contraceptive acceptance and usage and also of other beneficial health-seeking behaviours.

Despite the high level of awareness of usefulness of modern contraceptive (89.0%), the level of practice is low (3.3% to 38.5%). Omu & Unuigbo¹⁷ found a similar pattern among the Edo tribe in Nigeria. The fact that 66(72.5%) of the husband approved the use of the latest contraceptive method the mothers used is encouraging but not enough, wives' approval (84.6%) seem to carry a greater influence in contraceptive usage. A sex preference was the reason why about 10% of this group still had intention for further childbearing despite the grandmultiparity all because of yearning for a particular sex. Two thirds wanted boys while one third wanted girls. Among the 72 respondents, who had no intention for further childbearing seventy of them (97.2%) had definite intention to use contraception but incidentally less than half, 33(46%) planned to have bilateral tubal ligation (BTL). It is noteworthy that the knowledge of BTL is not so low (80.2%) among the patients studied but the acceptance might have been low for some reasons: there is a superstition that the person might not have fallopian tube when she reincarnates and the fear of going to the operating theatre cum anaesthesia.

This study may not be a true representation of the cross section of grandmultiparas among the Yoruba (the tribe of the area study) women because it is health facility based and located in city where education is the core industry. The educational strata of the respondents were bound to reflect high literacy rate and higher number of people with tertiary education (36.3%). This is however highly noteworthy because the findings did, not depart remarkably from other works, that have been quoted from studies in the general population. It may imply that cultural factors are independently more important than education in determining some health-seeking behaviours. By and large, the study has not been able to provide a satisfactory clue to the wide gap between knowledge and practice of modern contraception and the high level of unmet need among the respondents.

The findings from this study has some important implications for the health care providers and policy makers: Education can be a catalyst of positive changes and break the vicious cycle of poverty, deprivation, maternal and morbidity but it must be gradually insinuated into one's life from

the early formative years. It is by this effort that it can more effectively dismantle the strong hold of culture and religion on the reproductive health-seeking behaviours. Family planning programs and education should be taken to the grassroots by reaching out to all categories of health workers (both skilled and unskilled attendants) that manage pregnant women. This will expose more women to the need for better family planning for better quality of life from their first pregnancy before they get grandmultiparous. The fact that more works have to be done in educating the women about permanent method of contraception, especially (BTL) for the women has been brought to light in this study. If more people knew about it, the rate of unintended pregnancy due to failed contraception can be reduced¹⁵. The role of men in being the cornerstone for positive health-seeking behaviours that will result in the reduction of reproductive health morbidities and mortality in women cannot be over-emphasised and this is becoming more and more obvious to program planners¹⁸. Men will approve, support, remind, finance, utilize, seek and promote any issue that can help protect the lives and health of women as they become mothers if they are targeted for educational intervention in health programs.¹⁹

In conclusion, grandmultiparity is still a common feature of obstetric practice in Ile-Ife, Nigeria and this has been found to be associated with low level of contraceptive usage. An educational intervention programme taken to both rural and urban areas and introduced gradually from the primary school level will most likely close the wide gap in unmet need for family planning in this population, reduce family sizes, and have a positive impact on reduction in maternal and perinatal mortalities and morbidities.

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TABLE 1
Sociodemographic Characteristics of grandmultiparous attendees of ANC, in O.A.U.T.H.C., Ile-Ife, Nigeria in 2006. (n = 91).

| Sociodemographic Variables | Frequency (%) n = 91 |
|--|----------------------|
| 1 Education level attained:- | |
| - No formal education | 3 (3.3) |
| - Primary or basic Islamic education | 14(15.4) |
| - Secondary School | 41(45.0) |
| - Tertiary education | 33(36.3) |
| 2 Marital Relationship: | |
| - Monogamous Relationship | 59 (64.8) |
| - Polygamous Relationship | 32(35.2) |
| - Being the first wife/ the only wife. | 69(75.8) |
| - Being the second wife or the higher order. | 22(24.2) |
| 3 Parity:- | |
| Para 5 | 34 (37.3) |
| Para 6 | 30 (33.0) |
| Para 7 | 18 (19.8) |
| Para 8 | 8 (8.8) |
| Para 9 | 1 (1.1) |

TABLE 2
Awareness and usage of contraception among the grandmultiparous attendees of ANC in O.A.U.T.H.C. Ile-Ife, Nigeria in 2006. (n=91).

| N/S | Method of Contraception | Awareness | Ever usage | Proportion of usage to awareness | |
|-----|-------------------------|-----------|------------|----------------------------------|--------------------|
| | | f (%) | f (%) | Percentage(%) | Approximated ratio |
| 1 | Female Sterilisation | 73 (80.2) | ---- | ----- | ---- |
| 2 | Male Sterilisation | 47 (51.6) | ---- | ----- | ---- |
| 3 | Injectables | 89 (87.9) | 21 (23.1) | 26.3 | 1 : 4.00 |
| 4 | Norplant | 51 (56.0) | 3 (3.3) | 5.9 | 1 : 17.00 |
| 5 | Pills | 81 (89.0) | 28 (30.8) | 34.6 | 1 : 3 .00 |
| 6 | Male Condom | 85 (93.4) | 35 (38.5) | 41.2 | 1 : 2 .40 |
| 7 | Diaphragm / Foam /Jelly | 51 (56.0) | ---- | ----- | ---- |
| 8 | Periodic Abstinence | 73 (80.2) | 33 (36.3) | 45.2 | 1 : 2 . 20 |
| 9 | Coitus interruptus | 70 (76.9) | 31 (34.1) | 44.3 | 1 : 2 . 30 |
| 10 | Lactational amenorrhoea | 91 (100.) | 18(19.8) | ----- | 1 : 5 .00 |
| 11 | Traditional methods | 53 (58.2) | 4 (4.4) | 7.5 | 1 : 13 . 00 |
| 12 | IUCD | 76 (83.5) | 31 (34.1) | 40.8 | 1 : 2.50 |

TABLE 3
Cultural belief and attitudes towards the use of modern contraception among grandmultiparous attendees of ANC in OAUTHC Ile-Ife, Nigeria in

| Beliefs and Attitudes | Extent of Agreement | | | |
|--|---------------------|-------------------|---------------------|----------------------|
| | Agree f (%) | Disagree f (%) | Don't know f (%) | Indifferent f (%) |
| Husband should be the one to decide on Family Planning (FP) | 32 (35.2) | 47 (51.6) | 2 (2.2) | 10 (11.0) |
| Couple who practice FP have better quality of life than those who do not | 81 (84.0) | 7 (7.7) | 3 (3.3) | 1 (1.1) |
| Modern FP methods are safe and effective if correctly used | 78 (85.7) | 3 (3.3) | 7 (7.7) | 3 (3.3) |
| A woman should continue to bear children until she has a son | 3 (3.3) | 83 (91.2) | 1 (1.1) | 4 (4.4) |
| Your religion condemns the use of modern FP methods | 22 (24.2) | 65 (71.4) | 3 (3.3) | 1 (1.1) |
| FP methods help parents to take better care of their children | 87 (95.6) | 2 (2.2) | 1 (1.1) | 2 (2.2) |

TABLE 4
Paternal factors, contraceptive intentions and fertility needs among grandmultiparous attendees of ANC in OAUTHC, Ile-Ife, Nigeria in 2006

| Variables (n=91) | f (%) |
|---|-----------|
| Husband's involvement in FP: | |
| ❖ Latest contraception discussed with husband | 65 (71.4) |
| ❖ Latest contraception encouraged by husband | 59 (64.8) |
| ❖ Latest contraception approved by the husband | 66 (72.5) |
| ❖ Wife approved the latest FP method | 77 (84.6) |
| Future fertility | 72 (79.1) |
| ❖ No intention for further childbearing | 9 (9.9) |
| ❖ Intended to have at least a child more | 6 (6.6) |
| ❖ Intended to have a son (probe to know if none yet) | 3 (3.3) |
| ❖ Intended to have a daughter (probe to know if none yet) | 10 (11.0) |
| ❖ Undecided about future fertility plan | |
| Contraceptive intention | |
| ❖ Has not made up her mind on future use | 11 (12.1) |
| ❖ Will probably use | 11 (12.1) |
| ❖ Will definitely use | 70 (77.0) |
| ❖ Intended to use BTL | 33 (36.3) |
| ❖ Intended to use IUCD | 14 (15.4) |
| ❖ Intended to use injectables | 9 (9.9) |
| ❖ Intended to use pills | 2 (2.2) |
| ❖ Intended to use condoms | 4 (4.4) |