MedCrave
Step into the World of Research

Obstetrics & Gynecology International Journal

Research Article

Open Access

CrossMark

Explicative factors of the low uptake of modern contraceptives practice among women of childbearing age in Kumbo West Health District, North West Region, Cameroon

Abstract

Introduction: Contraception is a main pillar for reducing maternal mortality. Modern contraceptive (MC) prevalence is low in Cameroon.

Objective: To analyze the explicative factors of low uptake of modern contraceptives.

Material and methods: This was a cross-sectional analytic study in Kumbo West health district, in the North West Region, after the Catholic University Ethical Committee approval.

A total of 250 women were interviewed on their use of MC, their socio-demographic and reproductive health characteristics. Ever users and never users of MCs were compared. Data analysis was performed using EPI-info.7.2 Odds ratio, with its 95% confidence interval (CI) was used to appreciate associations between different variables and no use of MC. The level of significance was set up at $p<0.05$.

Results: Among the overall 250 participants, 99 had ever use MC (39.6%) and 44 women were currently under MC (17.6%). Never use of MC was associated with low level of education (68.5% vs. 31.5 %; AOR=3.64; 95% CI: 2.74-4.82; p=0.0001); living far from the health facility (84.0% vs. 16.0%; AOR: 3.32; 95%CI: 2.23-4.95; p=0.0001); lack of counseling on MC (93.6% vs. 5%; AOR: 2.71; 95%CI: 1.97-3.75); p=0.0001); lack of couple discussion on MC (83.7% vs.16.3%; AOR: 3.07 (2.22-4.25); p=0.0001); decision for MC use belonging to the partner (71.2% vs. 28.8%; AOR: 1.31 (1.9-1.45); p=0.0001); and low monthly income less than 36 000 CFA was associated to non-use of MCs (64.9% vs. 35.1%; AOR: 2.56; 95%CI: 1.81-3.62, p=0.0001).

Conclusion: MC Uptake is low in Kumbo and most explicative factors are modifiable. Program managers must use them for developing strategies if they are expecting to increase the MC use.

Keywords: low uptake, modern contraception, childbearing age, kumbo, Cameroon, explicative factors, low uptake

Volume 12 Issue 4 - 2021

Pierre Marie Tebeu,[1,2] Edward Dubila,[3] Jean Pierre Ngou Mve Ngou,[5] Theophile Nana Njamen,[4] Jesse Saint Saba Antaon,[2] Eugene Kongnyuy[6]

[1]Department Obstetrics and Gynecology Faculty of Medicine and Biomedical Sciences, University of Yaounde I, Cameroon
[2]Inters-states Centre for Public Health Training in Central Africa, Brazzaville, Congo
[3]School of Health Sciences, Catholic University of Central Africa, Yaounde, Cameroon
[4]Department of Obstetrics & Gynecology, University Hospitals, Libreville, Gabon
[5]Department Obstetrics and Gynecology, Faculty of Health Sciences, University of Buea, Buea – Cameroon.
[6]United Nation Population Fund, Bamako, Mali

Correspondence: Prof Pierre Marie Tebeu, MD, HPH, Faculty of Medicine and Biomedical Sciences, University of Yaounde, I, Cameroon,
Email pmtebeu@yahoot.fr, antaonjessesaintsaba@gmail.com

Received: July 17, 2021 | **Published:** August 02, 2021

Introduction

According to Cameroon DHS-2011(Cameroon demographic survey), 21% of births were unplanned; the prevalence of modern contraceptive (MC) use was 16% in the whole country and 20.9% in the North West Region.[1] Similar findings were reported in other Africa countries with 21% in Ghana and 43.9% in Nigeria.[2] Contraception is one of the pillars for improving reproductive health and could help in reducing maternal mortality.[3,4] Contraception can be administered even immediately after abortion and during and safely in breastfeeding period.[5,6] Previous study in Yaoundé, City Capital of the Republic of Cameroon revealed that, MC use was significantly higher in women whose partners approved contraception, and when family planning was discussed within the couple.[7] A previous report in Wum district, North West, Cameroon, revealed the current MC use rate of 13%.[8] In the Health District of Biyem Assi in Yaoundé, authors reported that 58.9% of women were under a MC use.[9] The same authors revealed that, this increased by 4.14- fold in women whose partners approved contraception and by 1.93-fold when family planning, was discussed within the couple.[9] Little is known about the determinants of low uptake of MC in rural Cameroon.

Objective

To identify the explicative factors of low uptake of MC in women aged 15-45 years in Kumbo West health district, in the North West Region.

Materials and methods

This was a cross-sectional analytic study from 1st of July 2015 to 30th of August 2015 after the Ctholoc University Ethical Committee approval. The target population was parous women with a pregnancy desire, living in the study area. A total of 250 women were interviewed after a clear oral consent. Based on WHO and UN reports, we explained to them and classified MC as chemical, mechanical barriers, hormonal, intrauterine devices and sterilization.[10] Data was collected using researcher-administered closed ended questionnaires. Variables of interest were age, religion, level of education, distance to nearest health unit, ethnicity, monthly income, discussion with the partner on MC, decider for MC use, been counseled on MCs and use of MC. The dependent variable was ever use of modern contraceptives from teen to the time of the interview. Data analysis was conducted using Epi-Info version 7.2. Odds Ratio with 95% confidence interval was

calculated to appreciate the effect of different variables on the risk of non-use of MC. The significant level was set up at p-value <0.05.

Results

Participant's age varied from 15 to 45 years with the mean at 25.8(SD: 6.9) in the non-MC users and from 17 to 45 with the mean at 26.95(SD: 6.5) for their counterparts. Among the overall 250 mothers, 151 had never use any MC (60.4%); 99 women had ever used any MC (39.6%), and 44 women (17.6%) were currently under MC.

Never use of MC was associated with low level of education (68.5% vs. 31.5 %; AOR=3.4; 95% CI: 2.74-4.82; p=0.0001); living far from the health facility (84.0% vs. 16.0%; AOR: 3.32; 95%CI: 2.23-4.95; p=0.0001); lack counseling on MC (93.6% vs. 5%; AOR: 2.71; 95%CI: 1.97-3.75); p=0.0001); lack of couple discussion on MC (83.7% vs.16.3%; AOR: 3.07 (2.22-4.25); p=0.0001); and decision for MC use belonging to the partner (71.2% vs. 28.8%; AOR: 1.3 (1.9-1.45); p=0.0001) (Table 1).

Table 1 Factors associated with Non use of modern contraception

Variables	Total N=250	Never use of MC N=151		Ever use of MC N=99		C0R (95%CI)	P-value	A0R (95%CI)	p-value
	n	n	%	n	%				
Age classes (years)									
[35-45]	30	22	77,33	8	26,67	2.04 (0.82-5.04)	0.119		
[25-35]	126	75	59,52	51	40,48	1.87 (0.77-4.52)	0.16		
[15-25]	94	54	57,45	40	42,55	1			
Religion									
Christian	184	102	55.4	82	44.6	1		1	
Muslim	66	49	74.2	17	25.8	2.31 (1.24-4.32)	0.0007	3.56a (2.76-4.59)	0.0001
Level of Education									
Secondary-Higher	139	75	54	64	46	1		1	
Up to Primary	111	76	68.5	35	31.5	1.85 (1.10-3.12)	0.0197	3.64b (2.74-4.82)	0.0001
Distance from the health unit									
≥5km	211	118	55.9	93	44.1	1		1	
<5km	39	33	84	6	16	4.33 (1.74-10.78)	0.0007	3.32c (2.23-4.95)	0.0001
Ethnicity									
Fulani	230	132	57.2	98	42.8	1		1	
Nso	20	19	95	1	5	4.33 (1.74-10.78)	0.0005	3.32d (2.23-4.95)	0.0001
Monthly income									
≥36000	42	16	38.1	26	61.9	1		1	
<36000	208	135	64.9	73	35.1	3.00 (1.51-5.96)	0.0012	2.56e (1.81-3.62)	0.0001
Discuss MC with partner									
Yes	158	74	46.8	84	53.2	1		1	
No	92	77	83.7	15	16.3	5.8 (3.09-11.0)	0.0001	3.07f (2.22-4.25)	<0.0001
Decider for use of MC									
Couple/self	138	72	51.8	66	48.2	1		1	
Partner	111	79	71.2	32	28.8	2.26 (1.33-3.84)	0.002	1.31g (1.9-1.45)	0.0001
Counseling on MC									
Yes	203	107	52.7	96	47.3	1		1	
No	47	42	93.6	5	6.4	7.54 (2.86-19.83)	<0.0001	2.71h (1.97-3.75)	0.0001

MC, modern contraceptives; 1=reference category; C, crude odd ratio; A, adjusted odd ratio; a, adjusted on level of education, ethnicity, b, adjusted on religion, ethnicity, income, the decider for use, discussion on MC and distance from health facility I, adjusted on religion, level of education, ethnicity, c, adjusted on discussion of MC with partner; d, adjusted on discussion of MC with partner; e, adjusted on religion, level of education, ethnicity; f, adjusted on religion, level of education, ethnicity; g, adjusted on religion; distance to nearest health facility; to the ethnicity. h, adjuster on the religion, level of education and monthly income

Discussion

The MC non-use rate was60.4% (151/250) with the MC ever use rate was 39.6%. In the District of Ho, in Ghana, 89.8% had ever used MC.[11] This low ever use of MC can be due to the fact that, our study took place in a semi-urban area and that is facing socio-cultural barriers.[12]

We found the current use of MC use rate of 17.6% was. The low current MC use rate lower that the half of the ever use rate indicate that, even if mothers start contraception; there is a challenge for retaining them. A previous report in Wum district, North West, Cameroon, revealed the MC use rate of 13% [8]. This rate close to the findings from present study can be justify by the fact that they all from the same region and both from rural area. Higher recourse to Mc was reported in some Africa countries; hence, the prevalence of MC was 22.7 in Nigeria, 33.2 in Ghana and 68.9% in Kenya.[13] In Ho health District, Ghana, and in Democratic Republic of Congo, authors reported MC prevalence among women in union ranged from 8.4% to 26.7%.[14] Higher MC use with was reported in the City capital of Cameroun (Health District of Biyem Assi in Yaoundé) with 58.9 of women currently under a MC use.[9] This could be partially explained by the urban status of the site of those studies where people would have high education level.

Low level of education (up to primary vs. at least secondary) was found in the present study (68.5% vs. 31.5 %; AOR=3.4; 95% CI: 2.74-4.82; p=0.0001). Improving women education and partner

involvement may increase the MC use by acting as proxy-factor for the knowledge on contraception as this may increase the opportunity of knowledge and providers location. Similarly in an Ethiopian study on postpartum contraception revealed that, educational status of mother increased by 4-fold the odds of postpartum modern contraceptive use.[15] Another study from the same country found that, the odds of using MC increased by 2.35-timesamong women with more than primary education.[16] In the same country, it was reported that, postpartum MC use was significantly associated with secondary levels (OR: 25) and tertiary (OR: 5.36) level of education.[17] This observation suggests that family planning must be considered only as a health issue, but as a development one.

Living at more than 5 Km from a health facility was associated with non-use of MC (AOR= 3.32; 95%CI: 2.23-4.95). In Uganda, perception of the distance from health facility as long was associated with low use of MC.[18] Long distance could constitute a geographical barrier and financial constrains for potential MC users. The long distance to the health facility, may act as barrier the contraceptive access, because, women will need money not only for contraceptive method, but also for transportation. Hence, in Ethiopia, authors revealed that, he percentage of rural married women who use modern contraceptives decreased as distance from the nearest health service increased and was for 2km (41.2%), 2-3.9 km (27.5%), 4-5.9 km (22.0%), and ≥6 km (22.6%).[19] Some experience like delivery of MC by community health workers could be implemented as have shown a promise in Uganda.[20] Those community health workers must be train to deliver quality counseling and family planning methods.

Lack of counseling was associated with non-use of MC (AOR: 2.71; 95%CI: 1.97-3.75). The quality of family planning counseling may influence the use and the continuity of MC use over time. This counseling must focus on type of different types of methods, potential side effects with her chosen method, and what to do in case of side effects. Our findings are in line with Ethiopian report revealing 5-times MC use among HIV patients who benefited from care providers counseling in Ethiopia.[21] Awareness is of great importance as knowledge on the mechanisms of action and side effects could influence the acceptability of the MCs.[7,22] Consequently, it has been reported that compared to women who did not benefited from counseling, women with prior counseling before delivery of long-acting MC in postpartum was less likely to have unwanted pregnancies confirming the efficacy counseling.[23] This observation is supported by A Pakistan study revealing that, compared to baseline, awareness of contraceptives increased by 30 percentage points among population in the intervention area.[24] A Counseling as an intervention during antenatal care Guinea, revealed that at the ninth month postpartum, use of modern FP was significantly higher in the intervention group than in the control group (5.7% and 1.1%, respectively; p=0.024).[25]

We also found that, lack of partner discussion on MCs was associated with non-use (OR: 3.07; 95%CI: 2.22-4.25). This is in line with previous report in Cameroon and Ghana.[7,26] Similarly, the Ethiopian study revealed 7.95-times increased odds of MC use among women who discussed about contraceptives with partner.[21] Discussing about MC suppose the possibility for deciding together. Therefore the self-decision by the partner observed in the present study (71.2% vs. 28.8%; AOR: 1.3 (1.9-1.45); p=0.0001), is also the consequence of this condition. In India, women who participated in household decision making had an increased odd of using MC (OR = 1.17 p<0.005).[27] The partner who participates to the decision in collaboration with the woman is more able to support her finally and psychologically in case of side effects.

Monthly income less than 36 000 CFA was associated to non-use of MCs (AOR: 2.56; 95%CI: 1.81-3.62). Similar findings were reported in Nigeria.[28] Similarly, a previous study revealed 5-fold increased risk of no use of MC among Ethiopian non-employed women.[29] This observation is in agreement with Indian observation; women who were working and who were paid in cash were more likely to use in last 12 months (OR = 1.37 p<0.005).[27] Need for financial support for better recourse to MC was reported in Pakistan, as Vouchers resulted in a net increase of 16% points in current CU and in 26% points in MC use.[24]

Conclusion

Currently use of MC was 17.6% and never use rate of MC was 39.6%. Never use of MC was associated with low level of education, living far from the health facility, lack of counseling on MC, lack of couple discussion on MC, decision for MC use belonging to the partner, and low monthly income. Most explicative factors are modifiable. Program managers must use them for developing strategies if they are expecting to increase MC use. We suggest the sensitization of couples and community based delivery through capacity building and empowerment for improving the MC uptake.

PMT: Initiation of the study, supervision, analysis and editing.

ED: Drafting the protocol, data collection, data entry, analysis and editing

TNN and EK: Did the study design, wrote the protocol and implemented the research.

JPNMN, EK, and JSSA: Did the literature search, crosschecked the statistical analysis and made important inputs in the drafting of the manuscript.

Acknowledgments

Authors would like to thank all the staff of the Kumbo West Health District, North West Region, Cameroon for their effort in implementation of modern contraception in the area.

Funding

None.

Conflicts of interest

The authors declare that they have no conflicts of interest.

References

1. DHS-2011, Cameroon. Contraception.
2. Beson P, Appiah R, Adomah-Afari A. Modern contraceptive use among reproductive-aged women in Ghana: prevalence, predictors, and policy implications. *BMC Womens Health*. 2018;18:157.
3. Chola L, McGee S, Tugendhaft A, et al. Scaling up family planning to reduce maternal and child mortality: the potential costs and benefits of modern contraceptive use in South Africa. *PLoS One*. 2015;10:e0130077.
4. Filippi V, Chou D, Ronsmans C, et al. Levels and causes of maternal mortality and morbidity. *Public health information*. 2016.
5. Korjamo R, Mentula M, Heikinheimo O. Expulsions and adverse events following immediate and later insertion of a levonorgestrel-releasing intrauterine system after medical termination of late first and second-trimester pregnancy: a randomised controlled trial. *BJOG*. 2017;124:1965–1972.

6. Polakow-Farkash S, Gilad O, Merlob P, et al. Levonorgestrel used for emergency contraception during lactation-a prospective observational cohort study on maternal and infant safety. *J Matern Fetal Neonatal Med*. 2013;26:219–221.
7. Njotang PN, Yakum MN, Ajong AB, et al. Determinants of modern contraceptive practice in Yaounde-Cameroon: a community based cross sectional study. *BMC Res Notes*. 2017;10:219.
8. Edietah EE, Njotang PN, Ajong AB, et al. Contraceptive use and determinants of unmet need for family planning; a cross sectional survey in the North West Region, Cameroon. *BMC Womens Health*. 2018;18:171.
9. Njotang PN, Yakum MN, Ajong AB, et al. Determinants of modern contraceptive practice in Yaounde-Cameroon: a community based cross sectional study. *BMC Res Notes*. 2017;10:219.
10. Festin MP, Kiarie J, Solo J, et al. Moving towards the goals of FP2. *Contraception*. 2016;94:289–294.
11. Afriyie P, Tarkang EE. Factors influencing use of modern contraception among married women in Ho West district, Ghana: descriptive cross-sectional study. *Pan Afr Med J*. 2019;33:15.
12. Asgary R, Price JT. Socio-cultural challenges of family planning initiatives for displaced populations in conflict situations and humanitarian settings. *Disaster Med Public Health Prep*. 2018;12:670–674.
13. Asaolu I, Nuno VL, Ernst K, et al. Healthcare system indicators associated with modern contraceptive use in Ghana, Kenya, and Nigeria: evidence from the Performance Monitoring and Accountability 2020 data. *Reprod Health*. 2019;16:152.
14. Casey SE, Gallagher MC, Dumas EF, et al. Meeting the demand of women affected by ongoing crisis: Increasing contraceptive prevalence in North and South Kivu, Democratic Republic of the Congo. *PLoS One*. 2019;14:e0219990.
15. Gejo NG, Anshebo AA, Dinsa LH. Postpartum modern contraceptive use and associated factors in Hossana town. *PLoS One*. 2019;14:e0217167.
16. Alemayehu GA, Fekadu A, Yitayal M, et al. Prevalence and determinants of contraceptive utilization among married women at Dabat Health and Demographic Surveillance System site, northwest Ethiopia. *BMC Womens Health*. 2018;18:118.
17. Abraha TH, Teferra AS, Gelagay AA. Postpartum modern contraceptive use in northern Ethiopia: prevalence and associated factors. *Epidemiol Health*. 2017;39:e2017012.
18. Asiimwe JB, Ndugga P, Mushomi J, et al. Factors associated with modern contraceptive use among young and older women in Uganda; a comparative analysis. *BMC Public Health*. 2014;14:926.
19. Shiferaw S, Spigt M, Seme A, et al. Correction: Does proximity of women to facilities with better choice of contraceptives affect their contraceptive utilization in rural Ethiopia? *PLoS One*. 2018;13:e0192258.
20. Hayward A, Brown K. A collaborative family planning program in rural uganda utilizing community health workers. *R I Med J*. 2019;102:25–27.
21. Araya BM, Solomon AA, Gebreslasie KZ, et al. The role of counseling on modern contraceptive utilization among HIV positive women: the case of Northwest Ethiopia. *BMC Womens Health*. 2018;18:121.
22. Rivera R, Yacobson I, Grimes D. The mechanism of action of hormonal contraceptives and intrauterine contraceptive devices. *Am J Obstet Gynecol*. 1999;181:1263–1269.
23. Shaaban OM, Abbas AM, Mahmoud HR, et al. Counseling and in-advance provision of levonorgestrel emergency contraceptive pills decrease the rate of unplanned pregnancy during breastfeeding: a randomized controlled trial. *J Matern Fetal Neonatal Med*. 2017:1–6.
24. Ali M, Azmat SK, Hamza HB, et al. Are family planning vouchers effective in increasing use, improving equity and reaching the underserved? An evaluation of a voucher program in Pakistan. *BMC Health Serv Res*. 2019;19:200.
25. Camara BS, Delamou A, Sidibe S, et al. Impact of an antenatal counseling on use of modern family planning methods in the postpartum in rural guinea. *Afr J Reprod Health*. 2018;22:16–25.
26. Wuni C, Turpin CA, Dassah ET. Determinants of contraceptive use and future contraceptive intentions of women attending child welfare clinics in urban Ghana. *BMC Public Health*. 2017;18:79.
27. Singh SK, Sharma B, Vishwakarma D, et al. Women's empowerment and use of contraception in India: Macro and micro perspectives emerging from NFHS-4 (2015-16). *Sex Reprod Healthc*. 2019;19:15–23.
28. Johnson OE. Determinants of modern contraceptive uptake among nigerian women: evidence from the national demographic and health survey. *Afr J Reprod Health*. 2017;21:89–95.
29. Seyife A, Fisseha G, Yebyo H, et al. Utilization of modern contraceptives and predictors among women in Shimelba refugee camp, Northern Ethiopia. *PLoS One*. 2019;14:e0212262.