Assessment of Contraceptives Uptake among Women Attending Immunization Clinics in Sabongidda-Ora.

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Abstract

Family planning and contraception allows a woman to determine the timing of her pregnancies and this has direct impact on her health and well-being as well as on the outcome of each pregnancy. According to World Health Organization, about one million girls aged below 15 years give birth each year while there are about 800 maternal mortalities everyday around the world. Meanwhile, contraceptive use reduced maternal death to around 26% in Nigeria in 2010.

Objective: To assess contraceptives uptake among women attending immunization clinics in Sabongidda-Ora.

Materials and method: a descriptive cross sectional study was carried out from November, 2017 to October, 2018 at Michael Imoudu Comprehensive Health Center, Sabongidda-Ora, Owan West Local Government Area of Edo State. The study population were women who brought their children for immunization. After determining the sample size, a systematic random sampling technique was used to select 388 women. Data was collected using pre-tested administered questionnaire.

Results: of the 388 women who participated in the study, the predominant age group was 25-29 years (34.0%); 291(75.0%) had secondary education; 366(94.3%)

were married while 230(59.3%) were from Owan tribe. Trading (44.1%) was the most prevalent occupation among the women. 81.7% said contraceptives are used to prevent pregnancy. 12.4% were current users while 59.3% had ever used any method of contraception. 86.1% of respondent believe that family planning was a good practice that every family should adopt. About 63.0% of the woman had spousal support. Good hygiene (43.3%), adequate privacy (26.7%), good facilities (20,0%) and proximity to residence (6.7%), were factors which gave satisfaction to respondents. Marriage with the desire to get pregnant (57.8%) and fear of side effects with menstrual problems (42,1%) were reasons for not using contraceptives

Conclusion: In spite of high level of awareness and good attitude towards contraceptive use, uptake was poor among the women.

Key words: family planning, contraceptives, women.

Introduction

Family planning according to WHO is a practice which allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.[1]

Family planning services are also considered as educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved.[2]

Family planning is sometimes used inter changeably with contraception, although family planning is much more than preventing pregnancies. It is more commonly used to refer to a couple deciding when to start and the interval between these births including sterilization and abortion decisions.[3]

Contraception is the use of any practices, methods, or devices to prevent pregnancy from occurring in a sexually active woman. Contraceptive methods are designed to inhibit the development and release of an egg, prevent fertilization of an egg or implantation of a fertilized egg in the uterus.

Planning helps couples to assess the availability of time, social, psychological and environmental resources to take care of their children. The couples can then decide on the appropriate steps to take to produce children their resources can cater for. This usually takes the form of preventing unwanted pregnancies, securing desired pregnancies, spacing of pregnancies and limiting the size of the family.[6]

The concept of responsible parenthood is promoted and in the interest of the health of the family, couples should have children by choice and not by chance.

Family planning services should be used as a tool for promoting family health and specifically for reducing maternal morbidity and mortality by preventing unwanted and high risk pregnancies. The WHO states that maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. Maternal mortality is unacceptably high. About 800 women die from pregnancy- or childbirth-related complications around the world every day. In 2013, 289 000 women died during pregnancy and following childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented.[7] Contraceptives use alone reduced maternal deaths in Nigeria by about 26 percent in 2010.[8]About 99 percent of maternal deaths occur in developing countries; more than half occur in sub-Saharan Africa and almost one third in South Asia; abortion accounts for about 20 to 40 percent of maternal death in Nigeria.[7, 9]In sub- Saharan Africa, the percentage of married women using family planning methods is about 23 percent out of which 18 percent are using modern methods while 5 percent are using traditional methods. More significant is the percentage with an unmet need for family planning services which is about 25 percent of the women which is higher than those who use family planning methods.[10] Many women in this sub-region are negatively influenced by various factors including misconceptions of contraceptive

side effects, male partner disapproval and sociocultural norms surrounding fertility.[11]

The contraceptive rate in Nigeria is 15 percent which is low especially when compared to a fertility rate of 5.5 children per woman in 2013, although the national goal is to achieve a contraceptive rate of 36 percent by 2018 through providing family planning services to the 16 percent of women with unmet needs in the country.[12,13]

Both early and late motherhood have increased risks. Young teenagers face a higher risk of complications and death as a result of pregnancy.[7]Couples ought to be able to decide how many and when to give birth to their children. They should have adequate knowledge and unhindered access to contraceptives which should be available in our health facilities and pharmaceutical stores. It is common place today to find women who get pregnant even when they are not yet ready for such pregnancies.

Adolescents should consider using a family planning method of their choice until they are 18 years old, before attempting to get pregnant. For couples who desire a next pregnancy after a live birth, they should wait at least 24 months before trying to become pregnant again in order to minimize the risk of adverse maternal, perinatal and infant outcomes. They should consider using a family planning method of their choice during that time. While after a miscarriage or abortion, couples are advised to wait at least six months before trying to become pregnant again.[14]

When planning a family, women should know that the older the couple the higher the chances of having births associated with Down syndrome, autism, multiple gestation, and decreased uterine tone leading to increased bleeding. The chances of having multiple births increases, which cause further late-pregnancy risks, they have an increased chance of developing diabetes in pregnancy, the need for operative deliveries are greater, older women's bodies are not as well-suited for delivering babies which are usually bigger than the average babies. The risk of prolonged labor is higher. Older mothers have a higher risk of a long labor, putting the baby in distress.

Throughout the world, family planning is a key strategy for reducing maternal, infant and child mortality and morbidity through the prevention of unwanted pregnancies and the promotion of healthy pregnancy spacing, protect against STDs, including HIV/AIDS; and provide other benefits to health.[15]

There is a noticeable rising trend of pregnancies among teenagers with an attendant increase in number of unsafe and illegal abortions. Unplanned unwanted pregnancies conceived from casual sex, due to rape, and by couples who have completed their desired family sizes is still rampant in our societies.

Edo State has one of the country's highest rates of commercial sex, international sex trafficking and risky sexual behavior. Many young women experience unwanted pregnancy and illegal abortion, about 600,000 annually.[16]

Unwanted pregnancy has been found to be a major factor leading to unsafe abortion, the complications of which lead to maternal morbidity and mortality which is a serious reproductive health challenge. According to a report by CNN, in Niger, a woman gives birth to an average of nearly eight children. Countries like Uganda, Mali and Somalia are close behind, with an average of six to seven children per woman. With every pregnancy and birth, a woman's risk of dying increases. Each pregnancy magnifies the mother's health risks, especially when she does not have access to health care including family planning services. Having pregnancies too close together does not give the mother time to recover after losing nutrients such as iron and folate after pregnancy and breastfeeding. This is called maternal depletion syndrome. Back-to-back pregnancies can deplete essential nutrients, making mothers at higher risk for anemia and other complications such as uterine rupture, and also putting their babies at risk of low birth weight and preterm birth. Also of note is the increased risk in taking care of someone who has had a significant number of children, especially for someone who gets past two to three children, the risks increase for complications like postpartum hemorrhage. After several pregnancies, the uterine muscles could fail to contract after delivery, which is the most common cause of postpartum hemorrhage. This excessive blood loss can be stopped with medical attention and immediate treatment such as a blood transfusion. But in many countries, these resources are not available. There may not be hospital staff, or even infrastructure to transport patients safely to the hospitals. The families may be unable to pay for hospital fees. In some Indonesian

hospitals, women cannot bring their babies home unless they pay for their hospital fees. Those who cannot pay may have to relinquish their parental rights and place their babies up for adoption, according to Robin Lim, a midwife who founded birthing clinics in Aceh and the island of Bali, in her native Indonesia. In places like rural Africa, women still have little control over their reproductive health, although they are well aware of the effects of numerous pregnancies. They also have multiple pregnancies because many of their children do not survive because of newborn complications and childhood diseases. They realize there is a toll on them, raising six to seven children, going through pregnancy six to seven times, often those times at home or in a clinic. They know they are at risk. Every day, about a thousand women in the world die from causes related to pregnancy and childbirth, according to the World Health Organization. The risk factors increase when women give birth when they are too young, too old, have too many or have pregnancies too close together. The WHO estimates that about 200 million couples in developing countries would like to delay or stop childbearing but do not use any method of contraception because of the lack of access, limited choices, fear and cultural or religious reasons. In poorer countries, there are some women who are not seeking to have large numbers of children. In many cases, they would like to limit family size. They do not have access to effective contraceptive that is affordable and acceptable and available to them. [17]

A study of more than 1.5million men and women found that becoming a parent has a clear effect on the chances of developing conditions from cancer and heart disease to becoming an alcoholic or dying in a car crash. But the relationship is not straightforward - it depends on the number of children a couple have. Too few or none at all, and they are at increased risk of dying from almost all of the conditions studied, perhaps because they lack the extra motivation to look after their health. But too many, and they struggle to cope with the financial and emotional stress of bringing up a large family.

A descriptive cross-sectional study carried out in public secondary schools in Ilorin to determine pregnancy outcomes among adolescents showed the following: all respondents were between 10-19 years with 53% being males. About one third (28.2%) of all the respondents were sexually active; 63.9% were males and 36.1% were females. Female respondents who had ever been pregnant constitute 5.7% of all sexually active female respondents while 17% of all sexually active males had

ever impregnated a girl. Abortion prevalence was 100% for females while 87.5% of males that have ever gotten a girl pregnant told the girls to abort the pregnancies. All the abortions were induced and done by unqualified personnel.[23]Similarly, it was found that 78.8% of the senior secondary school girls studied in Port Harcourt were sexually exposed. The youngest age of sexual initiation was 12 years. Most of their male consorts about 74.2% were older working men, pointing to possible financial as a contributing factor in these sexual activities. These teenagers who had low level of contraceptive awareness were also exposed to multiple sexual partners and therefore, would be expected to have a high prevalence of sexually transmitted infections and teenage pregnancy.[24]

Teenage pregnancy is a serious social problem. According to the March of Dimes, about three in 10 teenage girls become pregnant before the age of 20. While many of these pregnancies end in abortion or adoption, teen girls who do decide to keep their babies face many challenges. Although less is known about teen fathers, research indicates that they, too, face problems associated with being parents.

Pregnancy and parenting can strain the relationships between teen parents. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, eight out of 10 teen fathers do not marry the mother of their first child. Becoming a teen parent also seems to have long-term implications for marriage: in comparison to people who did not have babies as teens, teen parents are significantly less likely to be married by the age of 35 years. According to the American Academy of Child and Adolescent Psychiatry, depression is common among pregnant teens. Teen parents may feel guilty or anxious about the future. Teen parents are also more likely to subject their children to abuse and neglect because they feel overwhelmed by their unfamiliar, ever-demanding roles as parents. Teen parents also face problems in regards to the success of their children. Children born to teen parents earn lower standardized test scores and are more likely to drop out of high school. According to StayTeen.org, daughters born to teen mothers are three times as likely to also become teen mothers, while sons are twice as likely to go to prison.[26]

The United States has the highest rate of teenage pregnancy costing the country more than $7 billion per year, according to Family First Aid. Teenage parents face numerous challenges from parenting to finances. When a teenager is pregnant, she has not even started her career in most cases. Many teenagers will not even have

had a first job. Teenagers face the issue of medical care. If the parents have insurance, in many cases the teen mother is covered but the infant is considered his own person when born and will need to be covered separately. When parents do not have insurance to cover maternity care, the child and family may face the burden of paying for the maternity care, birth and postpartum care. The cost of maternity care and birth, without complications, averages between $9,000 and $17,000, according to Cost Helper. The pregnant teen may be eligible for Medicaid through the state if the family's income is below the minimum requirements. Once the infant is born, the teen mother's income will determine the eligibility for the infant and the infant may be covered under Medicaid. Child care is not a cheap expense yet required for a teen mother to finish school and work. A teenager who has little to no work experience is not likely to make much over minimum wage. Minimum wage may not even cover the cost of daycare in high-cost areas such as New York City. The cost of baby accessories add up quickly. Diapers, wet wipes, clothes, ointments, bottles, formula, and pacifiers are just the beginning. Adding these basic expenses to a teen mother who is working or in school can quickly overwhelm a new mom.[27]

According to World Health Organization, about 16 million girls aged 15 to 19 and some 1 million girls under 15 give birth every year—most in low- and middle-income countries. Complications during pregnancy and childbirth are the second cause of death for 15-19 year-old girls globally. Every year, some 3 million girls aged 15 to 19 years undergo unsafe abortions. Babies born to adolescent mothers face a substantially higher risk of dying than those born to women aged 20 to 24 years. There has been a marked, although uneven, decrease in the birth rates among adolescent girls since 1990, but some 11% of all births worldwide are still to girls aged 15 to 19 years old. The vast majority of these births (95%) occur in low- and middle-income countries. The 2014 World Health Statistics indicate that the average global birth rate among 15 to 19 year olds is 49 per 1000 girls. Country rates range from 1 to 299 births per 1000 girls, with the highest rates in sub-Saharan Africa. Adolescent pregnancy remains a major contributor to maternal and child mortality, and to the cycle of ill-health and poverty. For some adolescents, pregnancy and childbirth are planned and wanted, but for many they are not. Adolescent pregnancies are more likely in poor, uneducated and rural communities. In some countries, becoming pregnant outside marriage is not

uncommon. By contrast, some girls may face social pressure to marry and, once married, to have children. More than 30% of girls in low- and middle-income countries marry before they are 18 years; around 14% before they are 15 years. Some girls do not know how to avoid getting pregnant: sex education is lacking in many countries. They may feel too inhibited or ashamed to seek contraception services; contraceptives may be too expensive or not widely or legally available. Even when contraceptives are widely available, sexually active adolescent girls are less likely to use them than adults. Girls may be unable to refuse unwanted sex or resist coerced sex, which tends to be unprotected. Pregnancy and childbirth complications are the second cause of death among 15 to 19 year olds globally. However, there have been significant drops in the number of deaths in all regions since 2000, most notably in South-East Asia where mortality rates fell from 21 to 9 per 100 000 girls. Some 3 million unsafe abortions among girls aged 15 to 19 take place each year, contributing to maternal deaths and to lasting health problems. Early childbearing increases the risks for both mothers and their newborns. In low- and middle-income countries, babies born to mothers under 20 years of age face a 50% higher risk of being still born or dying in the first few weeks versus those born to mothers aged 20-29. The younger the mother, the greater the risk to the baby. Newborns born to adolescent mothers are also more likely to have low birth weight, with the risk of long-term effects. Adolescent pregnancy can also have negative social and economic effects on girls, their families and communities. Many girls who become pregnant have to drop out of school. A girl with little or no education has fewer skills and opportunities to find a job.

Objective of the study

1 To ascertain the level of knowledge of contraceptives use among the women.
2 To assess the attitude towards birth control and contraceptives use among the women.
3 To assess the uptake of contraceptives among the women.
4 To determine the factors influencing the uptake of contraceptives among the women.

Methodology

The research adopted a descriptive cross-sectional study design.The study was carried out in Sabongidda-Ora, the headquarters of Owan West Local Government Area, Edo State, Nigeria. There are three health facilities in Sabongidda-Ora: a general hospital, a comprehensive health centre and a specialist medical centre.The 1991 population census of Nigeria gives the total population of Sabongidda-Ora as 6,911 while the projected population at 3.2% annual growth rate is 15,881 as at 2017. The total population of women of reproductive age (15years – 49years) in Sabongidda-Ora as at 2017 is 3,494 which is 22% of 15,881.[12,7.]

Therefore,the study population were the women who brought their children to attend immunization clinics in Sabongidda-Ora, held atMicheal Imoudu Comprehensive Health Center, Sabongidda-Ora.

Selection Criteria:

Inclusion Criteria: Women of reproductive age group (15-49 years) attending immunization clinic and who must have lived in Sabongidda-Ora for at least six months.

Exclusion Criteria: Women who could not communicate in English Language were excluded from the study as the researcher could not speak the local dialect.

Duration of Study: The study was carried out over a period of one year from November, 2017 to October, 2018.

Sample Size Determination

The sample size was calculated using the formula[74]:

Sample size (n) = $\frac{Z_{1-\alpha/2}^2 P(1-P)}{d^2}$

Here, $Z_{1-\alpha/2}$ = standard normal variate (at 5% confidence level type 1 error is 1.96).

P = expected proportion in population based on previous or pilot studies.

d = absolute error or precision margin.

Error margin of 0.05 was used in this calculation.

Findings from a study done in 2015 at the Central Hospital, Benin City shows that 64.5% of women attending immunization clinic use any method of contraception.[35]Therefore, P = 64.5%(0.645), while (1-P) = 35.5%(0.355)
Substituting in the formula,
Hence sample size (n) = $\frac{1.96^2 \times 0.645 \times 0.355}{0.05^2}$

n = 351.9
≈352
Adding 10% non-response(35.2), the minimum sample size is 387.2
≈388

Sampling Technique

A systematic random sampling technique was used in this study. The only available immunization clinic in Sabongidda-Ora is at Michael Imoudu Comprehensive Health Center which has one immunization session per week. An average of thirty-three women attended each immunization session per week from January, 2017 to June, 2017 as obtained from Michael Imoudu Comprehensive Health Center immunization records which gives a total average attendance of seven hundred and ninety-two women over a six months period. The questionnaire were distributed over a six month period.[75]Dividing the total average attendance of seven hundred and ninety-two by the sample size of three hundred and eighty-eight gives a sampling interval of two. On every clinic day, the first respondent was randomly selected by balloting between number one and two from the list of women attending each immunization session followed by subsequent systematic selection of every second woman from the same list until the sample size is complete. Data was collected once a week during the immunization session which holds only on Wednesdays every week. Women who have been sampled had their names ticked in the immunization register to avoid multiple administration of questionnaire on them when they returned to the clinic for further immunization visits.

Data was collected using structured questionnaire containing open and close ended questions.

In analyzing the data that was collected from the field, the researcher made use of quantitative tools of data analysis since the study implored the use of closed and open ended questionnaire which were collated, screened for completeness and coded. Data obtained from the questionnaire were entered into the Statistical Package for Social Science (SPSS) version 21.0software for analysis. Univariate and bivariate analyses were done. Univariate tables were drawn for sociodemographic variables, bivariate analyses were used to assess relationship between dependent and independent variable using chi-square statistical test. Results were presented using descriptive statistical tools in the forms of tables, percentages, and bar charts. The level of significance was set at $P < 0.05$.

A total of three hundred and eighty-eight respondents were recruited for the study carried out among women attending immunization clinics in Sabongidda-Ora.

Table 1: Socio-demographic characteristics of respondents

Variables	Frequency (n = 388)	Percent
Age (years)		
15-19	14	3.6
20-24	70	18.0
25-29	135	34.0
30-34	108	27.8
35-39	37	9.5
40-44	22	5.7
45-49	2	0.5
Religion		
Christianity	376	96.9
Islam	12	3.1
Educational Level		
Primary	23	5.9
Secondary	291	75.0
Tertiary	74	19.1
Ethnic Group		
Owan	230	59.3
Yoruba	15	3.9
Ibo	20	5.2
Hausa	6	1.5
Kogi	21	5.4
Esan	16	4.1
Etsako	9	2.3
Others	71	18.3
Marital Status		
Single	11	2.8
Married	366	94.3

Divorced	2	0.5
Separated	9	2.3
Occupation		
Trading	171	44.1
Hairdressing	42	10.8
Tailoring	46	11.9
Teaching	33	8.5
Housewife	52	13.4
Catering	6	1.5
Farming	8	2.1
Others	30	7.7

A higher proportion of the respondents are within the age group of 25-29years 135(34.8%) while the least proportion of the respondents 2(0.5%) are in age group 45-49years.Most of the respondents 376(96.9%) practice Christianity while 12(3.1%) of respondents practice Islam.

About three-quarters of the respodnents, 291(75.0%) had secondary education,while those with tertiary education constituted 74(19.1%) of the study population. 23(5.9%) of respondents had at least primary education.
The majority, 230(59.3%) of the respondents were from Owan ethnic group. Most of the respondents 366(94.3%) were married and this was followed by single, 11(2.8%); separated, 9(2.3%) and divorced, 2(0.5%).

The predominant occupation was Trading 171(44.1%) while housewife, hairdressing, tailoring and teaching constituted 52(13.4%) 42(10.8%), 46(11.9%) and 33(8.5%) of the respondents respectively.

Table 2: Respondents' Knowledge of Contraceptives

	Frequency (n = 388)	Percent
Heard of Contraceptive		
Yes	388	100.0
No	0	0.0
Opinions on Contraceptive*		
Medicine used to abort Pregnancy	7	1.8
Medicine used to prevent Pregnancy	317	81.7
Medicine used to make a Woman Pregnant	3	0.8
Device Used to encourage spacing of Children	254	66.5
Medicine used to treat sexually transmitted infections	4	1.0
Known Contraceptives*		
Condom	336	86.6
IUD	35	9.0
Pills	162	41.8
Injectables	247	63.7
Implants	206	53.1
Vaginal Cap	13	3.4
Tubal Litigation	4	1.0
Others**	5	1.3
Sources of Information*		
Radio/Tv/Newspaper	129	33.2
Friends	79	20.4
Health Centers	341	87.9
Others	28	7.2

Multiple Responses*
Withdrawal, Calculation, Ovulation, Diaphragm, Vasectomy**

All the respondents 388(100.0%) were aware of contraceptive while almost all respondents 317(81.7%) and 254(66.5%) knew that contraceptive is medicine used to prevent pregnancy and as a device used to encourage spacing of children respectively. However, a small number of the respondents, 7(1.8), 3(0.8) and 4(1.0) were of the opinion that contraceptive is medicine used to abort a pregnancy, make a woman pregnant and treat sexually transmitted infections respectively.

The type of contraceptive mostly known to respondents was condom, 336(86.6%) followed by injectibles, 247(63.7%), implants, 206(53.1%), pills, 162(41.8%) while vaginal cap, 13(3.4%) tubal litigation, 4(1.0%) were not widely known.
More than three-quarters of the respondents, 341(87.9%) got their information on contraceptives from health centers, while about a third, 129(33.2%) from Radio/Tv/Newspaper.

Table 3: Respondents' awareness of emergency contraceptives use

Variables	Frequency (n = 388)	Percent
Awareness of emergency contraceptives		
Yes	253	65.2
No	135	34.8
Know how to use emergency contraceptives (n = 253)		
Yes	227	89.7
No	26	10.3
Respondents' idea of emergency contraceptives methods(n = 253)		
Postinor	126	49.8
Salt solution	100	39.5
Local gin	7	2.8
Ampiclox capsules	12	4.7
Andrew liver salt	8	3.2

About two-thirds, 253(65.2%) of the respondents were aware of emergency contraceptives while 135(34.8%) among them were not. Out of the 253 respondents who were aware of emergency contraceptives, 227(89.7%) reported knowing how

to use them. The respondents 'idea of contraceptives mostly show postinor tablet as the means of emergency contraception 126(49.8%) followed by salt solution 100(39.5%). Very few among the respondents 7(2.8%) indicated local gin while 8(3.2%) of respondents indicated Andrew liver salt as emergency contraceptives.

Table 4: Attitudes of respondents towards the use of contraceptives

Responses	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Family planning is a good practice that every family should adopt	68(17.5)	266(68.6)	12(3.1)	30(7.7)	12(3.1)
Contraception is only for women, men do not have to worry about it	37(9.5)	203(52.3)	11(2.8)	116(29.9)	21(5.4)
Women who use contraceptives may become promiscuous	14(3.6)	59(15.2)	26(6.7)	245(63.2)	44(11.3)
Contraceptives are for married people only	15(3.9)	142(36.6)	19(4.9)	172(44.3)	40(10.3)
Contraceptives use causes infertility in women	14(3.6)	78(20.1)	109(28.1)	168(43.3)	19(4.9)
Family planning has positive benefit on your health and family	40(10.3)	307(79.1)	18(4.6)	22(5.7)	1(0.3)
Contraceptive use is a reliable way of birth control	47(12.1)	286(73.7)	12(3.1)	37(9.5)	6(1.5)

Majority of the respondents 266(68.6%) and 68(17.5%) respectively agreed and strongly agreed that family planning is a good practice that every family should adopt. In the same vein, over half of the total respondents 203(52.3%) and 37(9.5%) also succumbed to the view that contraception is only for women, men do not have to worry about it. The observation that women who use contraceptives may become promiscuous was totally disagreed by greater proportion of the respondents 245(63.2%) while 142(36.6%) and 172(44.3%) respondents agreed and disagree respectively that contraceptives are for married people only.

Most of the respondents 307(79.1%) agreed that family planning has positive benefit on health and family while 286(73.7%) out of the total respondents also affirm that Contraceptive use is a reliable way of birth control

Table 5: Practice of contraceptives use among respondents

	Frequency (n =388)	Percent
Currently using a Contraceptive Method		
Yes	48	12.4
No	340	87.6
Type of Contraceptive in use (n=48)		
Injectables	16	33.3
Postinor	6	12.5
Condom	10	20.8
Implant	16	33.3
Time to commence the use of Contraceptives After Delivery of Baby		
When baby is 0-5 weeks old	7	2.1
When baby is 6-9 weeks old	79	23.3
When baby is 10-13 weeks old	31	9.1
When baby is 14-35 weeks old	18	5.3
When baby is 36-51 weeks old	13	3.8
When baby is ≥52 weeks old	30	8.8
No plan yet	147	43.2
Do not wish to use	5	1.5
When menses resume	10	2.9
Ever used a contraceptive method		
Yes	230	59.3
No	158	40.7
Reason for stopping (n=230)		
To get pregnant	125	54.3
After marriage	8	3.5
Fear of side effects	15	6.5
Menstrual problems	75	32.6

Abdominal bloating	7	3.0
Type of contraceptive used		
Injectibles	63	27.4
Postinor	50	21.7
Condom	24	10.4
Implant	4	1.7
Oral pills	59	25.7
Salt solution	28	12.2
Ampiclox capsule	2	0.9
Who took the decision to use contraceptive		
You	61	26.5
Your partner	24	10.4
Both	145	63.0

The proportion of respondents who were on contraceptives methods was 48(12.4%) while the larger percentage (87.6%) were not using any contraceptive method. The most predominant type of contraceptives adopted by respondents were injectables 16(33.3%) and implant 16(33.3%) respectively. On the contrary, greater proportion of the respondents 147(43.2%) who had not commenced the use of contraceptives had no plan in view yet, even though the least among them 5(1.5%) do not wish to adopt the use of contraceptives at all.

Most of the respondents 230(59.3%) were not consistent with the use of contraceptives and the reasons which constituted mostly 125(54.3%) respondents was to get pregnant. The others were menstrual problems 75(32.6%), fear of side effects 15(6.5%), after marriage 8(3.5%) and abdominal bloating 7(3.0%). The most common type of contraceptives used by the respondents 63(27.4%) was injectables of which 145(63.0%) respondents affirmed to the fact that it was a joint decision with their partner.

Table 6: Factors affecting contraceptives use among respondents.

	Currently using contraceptive Yes(n = 48)	Percent
Influence on Choice of Contraceptive(n=29)		
Long duration of action	5	17.0
Fear of side effects	5	17.0
Ease of use	6	20.7
Husband's choice	3	10.4
Health worker's advice	2	6.9
More effective	1	3.4
For better compliance	1	3.4
The only method known	6	20.7
Discussed Number of children with spouse		
Yes	45	93.8
No	3	6.2
Discussed Family Planning with Health Care Worker		
Yes	30	62.5
No	18	37.5
Satisfied With The Family Planning Services(n=30)		
Yes	30	100.0
No	0	0.0
Reasons for Satisfaction(n=30)		
Good health education and counselling	20	66.6
Care for clients	5	16.7
Skillful	0	0.0
Good reception	5	16.7
Health Center Conducive For Family Planning(n=30)		
Yes	30	100.0
No	0	0.0
Reasons for Health Center being Conducive(n=30)		
Clean and neat	13	43.3
Good facilities	6	20.0

Proximity to residence	2	6.7
Adequate privacy	8	26.7
Organized and comfortable	1	3.3
Planned Last Pregnancy		
Yes	37	77.1
No	11	22.9
Prevented from Using Contraceptives		
Yes	4	8.3
No	44	91.7
Cause Preventing the use of contraceptives(n=4)		
Husband/partner	3	75.0
Friends	1	25.0

Among the respondents who are currently using contraceptives, ease of use 6(20.7%) and the method of contraception known to the respondents 6(20.7%) had the most influence on choice of contraceptives by most of the respondents. While long duration of action and fear of side effects of contraceptives each influenced the choice of contraceptives of 5(17.0%) of respondents. Compliance with and effectiveness of contraceptives use had the least influence each 1(3.4%) on respondent's choice.

A greater proportion of the respondents 45(93.8%) had an earlier discussion with their spouses with respect to the number of children they planned to give birth to. On the contrary, most of the respondents 30(62.5%) had not discussed any family planning methods with a health care worker. Meanwhile, all the respondents, 30(100.0%) who had discussed family planning methods with a health care worker were satisfied with what they got. Their reason was justified with a good health education and counselling which constituted 20(66.6%) out of the total respondents.

Moreso, health centres were considered conducive for family planning by all 30(100.0 %) respondents who had discussed family planning methods with a health care worker owing to the fact that the environment was always clean and neat

(43.3%) and that the health centers had adequate privacy (26.7%), good facilities (20.0%) and were close their residences (6.7%).

Most of the respondents 37(77.1%) actually planned their last pregnancy while a good number of them 44(91.7%) had never been prevented from using contraceptives. Those who claimed to have been prevented from using contraceptives said their husband/partner 3(75.0%) and friends 1(25.0%) prevented them.

Conclusion

The level of awareness of contraceptive use was high among women attending immunization clinics in Sabongidda-Ora. They knew the commonly available methods of contraception like condom, injectables, pills and implants and that the health center was the most appropriate place to get contraceptives. The most predominantly used emergency contraceptive was postinor, although the knowledge of its use was poor.

The women have a positive attitude towards birth control and contraceptives use as majority of the respondents opined that every family should be planned. Additionally, there is a general belief among the women that contraceptives are a reliable way of birth control which is beneficial to the family's health.

The uptake of contraceptives among the women attending immunization clinic in Sabongidda-Ora was low. Very few of the women are currently using contraceptives with many more not having a plan to use. Only about half of the entire women had ever used a contraceptive method.

Factors such as age of respondent, discussing with the spouse about the number of children to give birth to, discussing family planning methods with a health care worker, good facilities, good hygiene, proximity of health centers to respondents' homes, were found to influence the uptake of contraceptives among women attending immunization clinic in Sabongidda-Ora.

Recommendations

Family planning focus groups should be formed at the community level where side effects of contraceptives can be exhaustively discussed to allay the fear of many women about the side effects of contraceptives use. Also women who develop symptoms attributable to contraceptive use should be given adequate medical care to reduce the chances of people developing wrong perceptions about these symptoms.

The health care workers should give more Health Education and counselling to the women on the proper use of emergency contraceptives.

Efforts should be made to maintain and improve on factors that encourage contraceptives use such as training and re-training of health care workers to continue to maintain their competences in delivering family planning and contraceptive services. Adequate facilities should be providedand maintained at the health centers.

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