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Factors Affecting Contraceptive Use among Reproductive Aged Women: A Case Study in Worawora Township, Ghana

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Authors' contributions

This work was carried out in collaboration between both authors. Author PL participated in conceiving the study. Authors SM and PL designed the study and participated in development of data collection tool. Author PL carried out data collection. Authors SM and PL participated in the statistical analysis and drafted of the final manuscript. Both authors read and approved the final manuscript.

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ABSTRACT

Background: Having more children in the past was a form of assurance to couples on the grounds of having more working hands to help till the land and cultivate crops. However, with the advent of modern farming technologies, pressure on social amenities, scarce resources, high dependency ratio, lack of employable opportunities and high incidence of poverty, a lot of people are trying to limit the number of children they give birth to by averting to the use of contraceptives.
Objective: The aim of this study is to determine factors affecting contraceptive use among reproductive aged women in the Worawora township of the Volta Region of Ghana.
Methods: A cross sectional survey using quantitative method was employed. A total of 390 women were conveniently sampled and questionnaires were administered to obtain the needed data. Bivariate and multivariate logistic regression analyses were deployed to understand the data.
Findings: Majority of the respondents were within the 15-24 age group and also predominantly Christians. The findings identified significant association between the use of contraceptives and

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age, number of children, number of members per household, occupation, marital status, educational level of partner and having a prior discussing with the sexual partner. Respondents in the age group 35-40 yrs were slightly over four times (*OR*: 4.33) more likely to use contraceptives compared to the younger aged women, after controlling for other covariates in the predictive model. There was a very progressive likelihood for a woman using contraceptive as the educational level of the partner increase. For instance, women whose partners have attained a tertiary level education were about seven (7) times more likely to use a form of contraceptive compared to those without any formal education. However, the respondent's marital status and occupation at the time of the study were found to have no statistical significant effect on predicting contraceptive use.

Conclusion: Women in their late thirties and those who indicated discussing the use of contraceptive with their sexual partners have higher tendency of usage. It was noted that partners' involvement and educational background has high impact on women's use of contraceptive. Policy decision should be driven to target those outside these age groups and demographic characteristics as measure to encourage usage.

Keywords: Contraceptive use; women of reproductive ages; Worawora, Biakoye District; Ghana.

1. INTRODUCTION

The utilization of contraceptives is one of the major determining factors for reducing fertility. This has increased steadily over the years and currently widespread throughout the world. However, progress has not been the same in terms of geographical areas, and problems still remain in terms of both increasing the level of use [1] to meeting current demand in certain regions and making available various types of methods to individuals wishing and willing to use contraception [2].

Globally, modern contraceptive utilization has increased in the recent past – from 54% in 1990 to 57% in 2012. However, the estimates in Africa remain persistently low at 23% and 24% respectively within the same time periods. The estimates among countries in the Sub-Saharan region are much lower than the aforementioned figures. This could be attributed among other factors to shortfalls in health infrastructure and transport facilities [3].

The persistent high rate of fertility in Ghana and more generally within the Sub-Sahara African countries, accompanied by declining mortality has given rise to unprecedented rapid population growth contributing to poverty, environment degradation and a deteriorating quality of life for majority of the people [2].

In Ghana, a country with multiple ethnic sects and religious groupings, efforts made by the Ghana Health Service (GHS) and other agencies to promote the use of contraceptives have resulted in a general increase over the last two decades. Currently, there is a steady decline in the total fertility rate from 1988-2014. Overall, the fertility in Ghana has reduced from 6.4 births per woman in 1988 to 4.2 births per woman in 2014. The disparity of use of family planning methods among the urban and rural, and rich and poor puts many women in most deprived settings at a disadvantage [4].

The average contraceptive prevalence rate in the Volta Region, one of the ten administrative regions of Ghana was estimated to be 30% relative to the national prevalence rate which increased from 13% to 27% from 1988-2014. Modern contraceptive methods also increased four times from 5% to 22% during the same period [4]. The total fertility rate (TFR) for the Biakoye district in the Volta Region where the study was done was 3.4 but with a general fertility rate (GFR) of 98.5 births per 1000 women aged 15-49 years as at 2014. There is a noticeable reported progressive increase in the number of people using contraceptive over the last couple of years; 234 in 2014, 612 in 2015 and 1,035 in the early section of 2016 [5].

A study conducted in the Talensi community in the Northern Region of Ghana to understand the major motivating factors to the usage of contraceptives among residents in that part of the country revealed the desire to adequately space the birth of children, prevent unwanted pregnancy and contraction of sexual transmitted infections were paramount. Whilst the acknowledged reasons for not accessing family planning services include opposition from husbands and misconceptions about family planning [6]. In the Upper East Region of Ghana, factors associated with the use of contraceptives as revealed by another empirical study included;

exposure to integrated primary healthcare services, the level of education, socioeconomic status, couple fertility preference, marital status, and parity [7].

This research therefore seeks to find out the factors affecting the contraceptive use among reproductive aged women in Worawora township of the Volta Region of Ghana.

2. METHODS

2.1 Study Population/Design

Two (2) sub-communities (Gyamarakrom and Kotomase) within the Worawora township of the Biakoye District in the Volta Region of Ghana were randomly selected from a list of several communities for participation in the study [8]. The study population comprised of all women in their reproductive ages (15-49years) within the selected communities. A cross-sectional study design was then deployed to determine the factors affecting contraceptive use among the selected women.

2.2 Sampling

A total of 195 reproductive aged women from each of the two chosen communities were conveniently picked as study participants. By this approach, the research team strategical paraded the homes in the communities and interviewed any woman who has consented to participate in the study and has met the defined criteria.

For an inclusive criterion, the following were given significant considerations; that the selected individual must have made a continuous stay in the study area over a 1-year period, must have been between the ages of 15 and 49 years at the time of the enrollment, and was capable of independent communication.

The estimated total sample size adapted for the study was determined using the formula; $n = \frac{Z^2pq}{e^2}$ Where n = estimated sample size; Z = standard normal deviate = 1.96; p = prevalence rate (usage rate in the Volta Region= 30%); q = 1 – p; and e = degree of accuracy, set at 0.05. Therefore, $n = \frac{(1.96)^2 x 0.3 x 0.7}{(0.05)^2} = 323 subjects$. A 20% attrition rate was then added to round up the sample size to about 390 participants which was split equally among the two communities.

2.3 Ethical Consideration

Ethical approval was obtained from Ensign College Ethical Review Board. Signed individual informed consent was obtained from each participant before the administration of the questionnaires. Study participants were informed of their right to opt out of the study at any time they felt uncomfortable with a posed questions or felt physical and mentally harmed in the course of the data collection. Respondents were assured of total confidentiality both for the data and their personality.

2.4 Data Collection and Analysis

Data was collected by trained interviewers using a semi-structured questionnaire which was interviewer-administered to respondents but pre-tested in an adjoining community with similar sociodemographic characteristics prior to use. The gathered data was then double entered into a computer using a platform created in Microsoft Excel. The two datasets were reconciled and all necessary corrections were effected using the information contained on the completed questionnaire as source document. The cleaned data was then imported into STATA Statistical software (Stata Corp. 2007. *Stata Statistical* Software *Release* 14 *StataCorp LP, College Station, TX, USA*) for analyses.

Socio-demographics and background data were summarized using frequency tables and graphs. A 95% confidence interval was used to describe the variability of the data. Bivariate analyses were conducted using Pearson's Chi–square test to assess the association between chosen variables. A multiple logistic regression model was further used to assess the likelihood of the independents variables in predicting "contraceptive use" of the respondents which in this case was coded as a dichotomous indicator.

3. RESULTS

Table 1 shows the demographic distribution of the 390 respondents who participated in the study. Majority (48%) of the participants were within the age range, 15-24 years. Half of the respondents had between 1-3 children and 38% had no biological children of their own at the time of the study. About 41% of the respondents were students, 19% were farmers whilst about the same proportion reported being traders. On the question of marital status, approximately 49%

reported being single and 38 out of the total participants representing close to 10% reported being either divorced or windowed at the time of participation. Most of the women (73%), professed faith in the Christian religion and about 3% belonged to the traditional religion. Respondents with an Akan ethnic background constituted about 41% of the studied population. As at the study period, 192 of the total respondents representing 49% indicated that the highest level of education attained by their sexual partners hinge around secondary level of education.

Table 1. Demographic distribution of respondents

Variable	Categories	n (%)
Age group	15-24	187 (48)
	25-34	120 (31)
	35-40	63 (16)
	41-49	20 (5)
Number of children	1-3	195 (50)
	More than 3	45 (12)
	None	150 (38)
Occupation	Student	158 (40.5)
	Civil servant	84 (21.5)
	Farmer	74(19)
	Traders	74(18.97)
Marital status	Married	162 (41.5)
	Single	190 (48.7)
	Divorced/ Widowed	38 (9.7)
Religion	Christianity	285 (73.1)
	Islamic	94 (24.1)
	Traditional	11 (2.8)
Ethnic group	Akan	160 (41.0)
	Ewe	127 (32.7)
	Guan	42 (10.7)
	Hausa	57 (14.6)
	Ga	4 (1.0)
Educational level of partner	None	16 (4.1)
	Primary	87 (22.3)
	Secondary	192 (49.2)
	Tertiary	95 (24.4)
Occupation of partner	Non-Government worker	224 (57.4)
	Government employment	93 (23.9)
	Student	73 (18.7)
Number of persons per household	1	44 (11.3)
	2-5	171 (43.8)
	6-8	119 (30.5)
	9 and above	56 (14.4)

The awareness level of contraceptive among the participants as seen from Table 2 was high, thus 377 out of the 390 respondents representing 97% have ever heard about a contraceptive method. Participants' knowledge on the purpose of contraceptives use was high; about three-quarters reported it is used to prevent pregnancy and 6% indicated it is a method used to prevent sexually transmitted diseases (STDs).

On the question of where they first heard about contraceptives, most of the respondents (35%) indicated they first heard about contraceptives from health workers, whilst about 30% heard it from television, 16% from friends and 14% from radio. When asked the type of contraceptive they currently use, majority of the respondents representing 35% reported using oral contraceptives, 14% used condom, 19% used injectables and a very insignificant proportion (0.5%) reported using the natural method. However, 25% of the study population indicated they aren't currently using any.

Majority of the respondents (58%) mentioned they have access to contraceptive method from the hospital and only 13% indicated they get it from friends. Rest of the respondent however reported getting it from chemical shops.

About 54% of the respondents reported that their religious doctrines accept the use of contraceptives, whilst 48% needed approval from their partner to use contraceptives. A further probe into approval for usage indicated about 55.4% of the respondents did not inform their partners before using a method.

Most (82%) of the study respondents preferred to have less than 4 children. The use of contraceptive was high, with 74% of the respondents using it.

The results from the bivariate analysis (Table 3) revealed some interesting findings among the participants. On the sociocultural factors, there was a significant association ($p< 0.001$) between the use of contraceptive and the woman having a discussing with partner before usage. There was also an observed strong association between the partner's level of education and choice of occupation with the woman's desire for contraceptive usage. Partners who support having less than four children shows a statistically significant association ($p<0.04$) with the respondents' use of contraceptives.

Table 2. Respondent's level of awareness and perception on contraceptives

Variables	Categories	n(%)
Heard about contraceptive	Yes	377(96.7)
	No	13(3.3)
Source of information	Radio	56(14.4)
	TV	116(29.74)
	Health Worker	135(34.62)
	Friends	64(16.41)
	Family	19(4.87)
Known contraceptive	Condoms	86 (22.8)
	Injectable	94 (24.9)
	Pills	153 (40.6)
	Implants	34 (9.0)
	All	9 (2.4)
	Natural method	1 (0.3)
Access to contraceptives	Hospital	227(58.2)
	Friends	52(13.3)
	Chemical Stores	111(28.5)
Purpose of contraceptive use	Used to prevent pregnancies	281(74.5)
	Used when you want to have few	75(19.9)
	Used to prevent STDs	21(5.6)
Contraceptive used currently	None	99(25.38)
	Condoms	54(13.85)
	Injectable	76(19.49)
	Oral	135(34.62)
	Implants	24(6.15)
	Natural Method	2(0.51)
Partner's occupation	Self-employed	224 (57.4)
	Government workers	93 (23.9)
	Student	73 (18.7)
Religion encourages the use of contraceptives	Yes	211 (54.1)
	No	179 (45.9)
Do you need approval from your husband before using contraceptives	Yes	185 (48)
	No	205 (52)
Discuss with your partner before using contraceptives	Yes	174 (44.6)
	No	216 (55.4)
Partner support you in having less than 4 children?	Yes	252 (64.6)
	No	138 (35.4)
Prefer to have less than four(4) children	Yes	319 (81.8)
	No	71(18.2)
Belief say about the use of contraceptives?	Accept the use	217 (55.6)
	Does not accept the use	173 (44.4)
Perceived cost of contraceptive	Cheap	133 (45.9)
	Moderate	121 (41.7)
	Expensive	31 (10.7)
	Very expensive	5 (1.7)
Relationship of the staff to you	Nice	149 (51.4)
	Very nice	87 (30.0)
	Rude	27 (9.3)
	Very rude	27 (9.3)

Conversely, there was no statistical significant association between the respondents' professed religious beliefs and practices with the use of contraceptives.

The findings from both adjusted and unadjusted logistic models (Table 4), indicates respondents in the age group 35-40 yrs have a strong predictive likelihood of using contraceptives compared to their colleagues in the younger age group (15-24) years. In the adjusted model, these individuals were 4.33 times more likely of using contraceptives as compared to their counterparts in the younger aged group. Respondents in the older age group though still productive, have a negative odds (0.46) times of using contraceptives compared to the very youth counterparts. This could come as a results of not having any or the desired number of children and will therefore not

attempt the use of any pregnancy preventive scheme.

Individuals coming from home with more than nine (9) members were also statistically less likely to use contraceptive as compared to those who are single occupants of a home. It was further observed from the data that respondents whose partners do not support the idea of having less than four children were about three (3) times more likely to use contraceptive after controlling for other independent variables in the predictive model as compared to those whose partners will encourage more children. The respondents who indicated farming as the primary occupation have a very high odds (OR: 36.41) for using the contraceptives compared to those who were students at the time of participation. This could explain the fact that most couples are no longer giving births to with the hope to have them serve as helping hands on their farms. Human society is dynamic and the trend have now shifted instead to taking up office type jobs.

There was a very progressive odds of a woman using contraceptive as the educational level of the partner increases. For instance, women whose partners have attained a tertiary level education were about seven (7) times more likely to use a form of contraceptive compared to their colleagues whose partners have no formal education after adjusting for other covariates. Women who had discussed with their partners the need for usage were 58.69 times more likely to use contraceptives as compared to their colleagues who might not done that.

However, the marital status and participant's occupation at the time of the study were noted as predictive factors that do not statistically have a significant effect on the choice of using contraceptive among the study participants in the Worawora township.

Table 3. Results of bivariate analysis on the use of contraceptive among women in Worawora

Variables	Categories	Contraceptive use		p-value
		Yes	No	
		n (%)	n (%)	
Age group	15-24	136 (72.7)	51 (27.3)	<0.001
	25-34	93 (77.5)	27 (22.5)	
	35-40	54 (85.7)	9 (14.3)	
	41-49	7 (35)	13 (65.)	
Number of children	More than 3	33 (73)	12 (27)	0.007
	1-3	158 (81)	37 (19)	
	None	99 (66)	51 (34)	
Number of person per household	1	37 (84.1)	7 (15.9)	0.002
	2-5	134 (78.4)	37 (21.6)	
	6-8	89 (74.8)	30 (25.2)	
	Above 9	30 (53.6)	26 (46.4)	
Occupation	Student	106(67.1)	52(32.9)	0.030
	Civil servant	63(75.0)	21(25.0)	
	Farmer	62(83.8)	12(16.2)	
	Traders	59(79.7)	15(20.3)	
Marital status	Married	126(77.8)	36(22.2)	0.030
	Single	131(69.0)	59(31.1)	
	Divorced/Widowed	33(86.8)	5(25.6)	
Religion	Christianity	206 (72.3)	79 (27.7)	0.327
	Islamic	75 (79.8)	19 (20.2)	
	Traditional	9 (81.8)	2(18.2)	
Partner supports less than 4 kids.	Yes	179 (71)	73 (29)	0.042
	No	111 (80.4)	27 (19.6)	
Education level of partner	None	8 (50)	8 (50)	0.003
	Primary	58 (66.7)	29 (33.3)	
	Secondary	143 (74.5)	49 (25.5)	
	Tertiary	81 (85.3)	14 (14.7)	
Occupation of partner	Student	45 (61.6)	28 (38.4)	0.003
	Gov't worker	79 (85)	14 (15)	
	Self-Employed	166 (74.1)	58 (25.9)	
Discuss with partner	Yes	170 (97.7)	4 (2.3)	< 0.001
	No	120 (55.6)	96 (44.4)	

Table 4. Results from unadjusted and adjusted logistic regression analyses

Variables	Categories n=390	n (%)	Unadjusted		Adjusted	
			p-value	OR (95%CI)	p-value	OR (95%CI)
Age groups	15-24 *(Reference)*	187 (48)	-	1.00	-	1.00
	25-34	120 (31)	0.349	1.29 (0.76- 2.21)	0.200	1.61(0.77-3.32)
	35-40	63 (16)	0.040*	2.25 (1.04-4.89)	0.014*	4.33(1.35-13.85)
	41-49	20 (5)	<0.001*	0.20 (0.08-0.53)	0.261	0.46(0.12-1.79)
Person per	1 *(Reference)*	44 (11.3)	-	1.00	-	1.00
Household	2-5	171 (43.8)	0.403	0.69 (0.28-1.66)	0.894	1.07(0.37-3.16)
	6-8	119 (30.5)	0.212	0.56 (0.23-1.39)	0.910	0.94(0.30-2.95)
	>9	56 (14.4)	0.002*	0.22 (0.08-0.57)	0.008*	0.17(0.05-0.64)
Occupation	Student *(Reference)*	158 (40.5)	-	1.00	-	1.00
	Civil servant	84 (21.5)	0.203	1.47(0.81-2.67)	0.105	17.79(0.55-575.55)
	Farmer	74(19)	0.009*	2.53(1.26-5.11)	0.045*	36.41(1.08-1224.84)
	Traders	74(18.97)	0.050	1.93(1.00-3.72)	0.545	1.37(0.50-3.78)
Marital	Single *(Reference)*	190 (48.7)	-	1.00	-	1.00
Status	Married	162 (41.5)	*0.064*	1.58(0.97-2.55)	0.106	0.06(0.00-1.84)
	Divorced/Widowed	38 (9.7)	0.031*	2.97(1.11-8.00)	0.385	1.96(0.43-9.03)
Partner	Yes *(Reference)*	252 (64.6)	-	1.00	-	1.00
supports less than 4 kids	No	138 (35.4)	0.043*	1.67(1.02-2.77)	<0.001*	2.92(1.55-5.49)
Educational	None *(Reference)*	16 (4.1)	-	1.00	-	1.00
Level of	Primary	87 (22.3)	0.207	2.00(0.68-5.87)	0.085	4.32(0.82-22.84)
Partner	Secondary	192 (49.2)	0.042*	2.92(1.04-8.19)	0.029*	6.46(1.22-34.35)
	Tertiary	95 (24.4)	0.002*	5.79(1.86-17.95)	0.030*	6.94(1.21- 39.79)
Discussed	No *(Reference)*	216 (55.4)	-	1.00	-	1.00
with Partner	Yes	174 (44.6)	<0.001*	34.00(12.17-94.96)	<0.001*	58.69(18.38-187.41)

**Denotes statistical significance at a chosen a-level of 0.05,*
Hosmer-Lemeshow goodness-of-fit test for the Adjusted Multiple Logistic model (p-value= 0.2557)

4. DISCUSSION

Islam et.al found low awareness of contraceptive use among the Mru ethnic group in Bangladesh [9]. In contrast, women from the two sub-communities in Worawora township were aware and had a high proportion using contraceptives. This could be attributed to the fact that majority of the women did report their source of information were from attending healthcare providers where they often sought for medical care and also make enquires on the use of contraceptives. The public health unit in these facilities provide them with health education, a practice which might have increased their understanding on the importance of contraceptives usage. Majority of the respondents were students and may be influenced by their peers to use contraceptives. Besides, most of them are literates and could read about the topic from available literature as well. This has buttressed the findings from Hagan et. al. who asserted that students with knowledge of contraceptives were users and most obtained their knowledge about contraceptives from peers (friends) [10].

An empirical study conducted by Fallis et.al. indicated that most women had high level of knowledge about contraceptives but this did not translate into the use [2]. This however is not the case among the study participants from the Worawora community, as majority (75%) were using a method of a kind. A study in South Africa, revealed that majority of the respondents were using oral contraceptive pills (35%) this could be due to the fact that oral medication is not an invasive procedure and will be uncomfortable taking at home [11]. Oral contraceptive may also be gotten at the chemical shop and respondents will get it as and when they need it. Adolescents may shy away from the hospital for injectables or IUD for the fact that they may be labeled as been promiscuous. Afolabi et.al., found schools/educational institutions as the major sources of contraceptives information [12] in contrast to this study where majority had their information from health workers.

In the unadjusted model, the divorced or widowed were more likely to use contraceptives. This could be attributed to the fact that such women are still sexually active (370 out of the total of 390 were aged between 15-40 yrs) and would want to protect themselves from getting any unwanted pregnancy before officially getting married to the next lover. This finding however was not significant in the adjusted

model, as the marital status has no statistical effect to the usage of contraceptive in this population. This is in contrast to the GDHS report of married women in Ghana using more contraceptives [4].

Religious beliefs and practices of the respondents was also identified in other study to have some level of influence on the use of contraceptives [13]. However in this particular study, the professed religious affiliation of the women was not significantly associated to the use of contraceptives. This may be because a much greater proportion did report their religion encourage the use of contraceptives.

As people get educated, it is expected that they are better informed which should translate in the choices they make. The educational level of partners do have a corresponding effect with the respondents' use of contraceptives as they complement one another in their decision making process. A study by Okeck et al. found various socio-economic and demographic factors to be associated with use of contraceptives, including level of education of the women and partner [14]. In our study, respondents whose partners had up to a secondary level education and above were more likely to use contraceptives compared to their illiterate counterparts.

Having a prior discussion regarding contraceptives with partners before actually using it was statistically significant in predicting usage. Those who discussed the use of contraceptives with their partners were more likely to use contraceptives. This is because both partners are likely to understand the family dynamics and would together agree to use contraceptive to evenly space child birth or control the number of children they would desire to have. According to Sable et.al., partners, peers and family strongly influence contraceptive use [15].

The number of people per house hold was significantly associated with the use of contraceptive, this could be due to the fact that people within a household do share ideas together and anybody using a method could encouraged the other to do same. Alternatively, the higher household size could translate to mean more economic stress on the number of people eating from the same pot. This would explain the reason for using contraceptives to avoid increasing such burden.

5. CONCLUSION

Majority of the respondents in the study professed faith in the Christian religion and reported having heard about contraceptive prior to participation with the largest age group falling above 25 years and above. There was a very noticeable and progressive odds of a woman in the study population using a conceptive method given the educational level of the sexual partner. Thus, women whose partners have a tertiary level of education were about seven times more likely to use a contraceptive compared to their counterparts whose partners have no formal education.

From the predictive models, it became significantly clear that the key factors that influence the use of contraceptive is tied more closely to the partners' involvement (including holding discussion on usage) and their educational background. Efforts should therefore be made to actively involve the men alongside empowering women through education on ways to access contraceptives and it importance in addressing the sociocultural and economic challenges of the family and community at large.

It was further observed from the data that a woman's chance of using contraceptive dwindles as the size of the household increases with a more statistically significant effect when it gets to over nine members. This could be attributable to the fact that, by attaining the high household size, the woman might be getting closer to be out of the reproductive age bracket and is less motivated to use any preventive measure given the vast experiences she had gain on child birth.

6. STRENGTH AND LIMITATIONS

The recognized strength from this study comes to the fact that, the Sub-Saharan Africa region including Ghana bears a very significant proportion of the global health burden. Unfortunately, little is done in terms of rigorous scientific research to unearth and understand the realities on the ground. Findings from this project will contribute immensely in generating some needed information to fill the knowledge gap. It will also be the basis for which other related future studies could be done.

This notwithstanding, there are some limitations to the study. The small nature of the sampled size used could make it impossible to generalize the key findings to a larger population. Secondly,

some information gathered from the respondents could be subjected to sampling bias given the sampling technique adapted. Further comprehensive research work could be done as a follow up study.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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