

COVERT CONTRACEPTIVE USE AMONG WOMEN OF REPRODUCTIVE AGE IN IBADAN, NIGERIA

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ABSTRACT

BACKGROUND: This study assessed the prevalence and determinants of covert contraceptive use among women of reproductive age in Ibadan, Nigeria.

METHODS: A cross sectional study among women attending a family planning clinic in a maternity teaching hospital in Ibadan, Nigeria was conducted. Data was collected on sociodemographic characteristics, contraceptive use and partner awareness of use. The socio-demographic predictors of covert contraceptive use were explored using logistic regressions.

RESULTS: Twenty-five (6.8%) of the 365 respondents were practicing covert contraception. Their mean age was 34.7±6.67 years, 98.6% were married and with modal parity of 3 (29.6%). A logistic regression analysis showed that participants' age ($p = 0.555$), occupation ($p = 0.679$), education ($p = 0.642$), parity ($p = 0.385$) and husbands' education ($p = 0.926$) were not statistically associated with covert contraceptive use while husbands' financial supports ($p = 0.000$) and approval for family planning use ($p = 0.000$) were associated with reduction in the likelihood covert contraceptive use.

CONCLUSIONS: Covert contraceptive use exist among our women. Poor financial support and disapproval by the husbands were the strongest predictors of the practice. Greater male involvement in contraceptive service provision will help address these negative factors promoting covert contraceptive practices.

KEY WORDS: covert, contraception, women, reproductive age.

RUNNING TITLE: Covert contraceptive in Ibadan, Nigeria

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INTRODUCTION

Covert contraception is defined as contraceptive use without the knowledge of the spouse or without direct involvement of the patient's partner. It also includes the secret use of contraception without the knowledge of extended family members^{1,2} or even field researchers. It represents the individual's decision to practice contraception without the direct involvement of others.

This practice has largely affected the assessment of contraceptive behaviour of people in sub-Saharan Africa by researchers which have been

compounded by the fact that some women hide contraceptive use from family members and broader social circles rather than from sex partners especially among unmarried young adults and adolescents. It is said that any family planning programs that attempt to reach women will have a higher probability of success if they also involve their husbands or at least encourage such involvement.²

Reproductive decisions made by men do not necessarily reflect their wives' reproduction preferences and may even be directly opposed to those preferences. In general, 15-20 percent of couples gives discrepant response to questions about the current use of contraception and in most cases, the husband more often reports use than the wives.^{3,4}

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Many modern methods available to women can be used covertly; these include: oral contraceptives (including emergency contraception), injectables, the Intrauterine Contraceptive Device and Subdermal implants.³

Studies of spousal differences in reports of current contraceptive use have shown large discrepancies between what wives and husband report. The practice of covert contraception has been largely affected in the sub-Saharan Africa by masculine dominance and the inability of women to take decisions on matters regarding their reproduction. Covert contraceptive use is therefore a sign that providers must continue to consider women's rights to confidentiality in family planning services.

This study seeks to assess the prevalence and the motivation for the practice of covert contraception among women of reproductive age in Ibadan, Oyo State Nigeria.

METHODOLOGY

Study Design and Location

This cross sectional descriptive study was among women of reproductive age attending the family planning clinic of the Adeoyo Maternity Teaching Hospital, Ibadan, Oyo state, Nigeria. Adeoyo Maternity Teaching Hospital is a government owned specialized service hospital in Ibadan North Local Government area of the state. It is one of the busiest maternity hospitals in the country. It was established in 1927 to provide mainly obstetric services at the secondary level of health care. As a necessity, the hospital has other units like the gynaecological, neonatal and infant welfare clinics. The patients' diversity represents all social status in the state in a probably balanced proportion making it a less skewed health facility to produced generalizable results from studies.

Study Population

The eligible participants in the study were all women of reproductive age who were using at least one modern family planning method attending the family planning clinic of the hospital for contraceptive services between January 2nd 2016 and February 29th 2016.

Data Collection Procedure

Data was collected by trained research assistants with supervision and guidance provided by the investigators using a questionnaire that converted

the objectives of this study to research questions. The questionnaire inquired about sociodemographic characteristics of the participants, type and duration of use of the method and male partner awareness of the use of a method (using the question "Is your partner aware that you are using a modern method of family planning"). Other questions in the questionnaire include those about motivations for the practice of covert contraception.

The interviews were conducted in English language or the local languages of Yoruba, Hausa or Igbo depending on the participant's preferred language. Privacy was ensured with the use of a private room provided within the hospital by the management of the health facility. Using modified Leshlie Kish formula⁵, a target sample size of 391 women was set to afford 95 % confidence level in estimating the prevalence of CCU within a margin of error of 5 %, assuming a covert use prevalence of 47 %⁶ and 10% refusal rate.

The Oyo State Research and Ethics Committee approved the study and consent was obtained from each of the participants ensuring confidentiality of the information provided and anonymity of their participation.

Data Management

Data from the completed questionnaires were entered into computer and analysed using Statistical Package for Social Science statistical (software, version 22.0 (SPSS Inc., Chicago, Illinois). The analyses were descriptive and exploratory of the relationship between covert contraceptive use, sociodemographic characteristics, and the motivations for covert contraceptive use. At logistic regression, an association was considered to be significant if the *p*-value was less than 0.05. The findings are reported in two tables that show factors related to the sociodemographic characteristics of respondents and factors that are related to motivations for covert contraceptive use.

RESULTS

A total of 365 of the 391 questionnaires administered were found suitable for analysis (12 questionnaires were refused and 14 were not, completely, filled). The mean age of the respondents was 34.7±6.67 years and modal age

class was 31-35 years. Majority (47.1%) of the participants had Senior Secondary School Education while 28.7% had Primary Education, 19.5% had Post-secondary Undergraduate Education (Diploma and First degree), 2.7% had no Formal Education and 1.6% had Post-Secondary Postgraduate Education. Most of the participants (98.6%) were married. The modal parity of the respondents was 3 children and constituted 29.6% of the total respondents (Table 1). Twenty-five of the respondents did not inform their husband of their practice of contraception giving a covert contraceptive use prevalence of 6.8% among these respondents (Fig. 1). In all, 96.7% of the respondents' husbands had at least secondary education with 96.2% providing at least

some financial supports and 88.2% gave approval to the respondents to use contraception (Table 1). A logistic regression was performed to ascertain the effects of Age, Occupation, Level of Education, Husband Education Level, Parity, and Husband Financial Support on the practice of Covert contraception. From these results age ($p = 0.555$), Occupation ($p = 0.679$), Husband Education ($p = 0.926$), Parity ($p = 0.385$) and Level of Education ($p = 0.642$) were not statistically associated with covert contraceptive use (Table 2). However, increasing financial support from the husband ($p = 0.000$) and approval for contraception use from husband ($p = 0.000$) were associated with a reduction in the likelihood of covert contraception (Table 3).

Table 1: Background Characteristics of the Respondents

A. Personal Characteristics		
<i>Characteristics</i>	<i>Frequency</i>	<i>Percentage</i>
Age (Years)		
20-25	28	7.7
26-30	76	20.8
31-35	97	26.6
36-40	94	25.8
41-45	51	14.0
=46	19	5.2
Mean age 34.7±		
Level of Education		
No Education	10	2.7
Primary	104	28.7
Secondary	172	47.1
Diploma	48	13.0
First Degree	25	6.5
Higher Degree	6	1.6
Marital status		
Married	360	98.6
Divorced/Separated	5	1.4
Parity		
1	24	6.6
2	64	17.5
3	108	29.6
4	100	27.4
=5	69	18.9
Occupation		
Trading	231	63.3
Civil Servant	33	9.0
Housewife	5	1.4
Others	96	26.3
Family Planning methods		
Condom	6	1.6
Injectibles	56	15.3
IUCD	279	76.4
Oral Contraceptive Pills	3	0.8
Subdermal Implant	21	5.8
B. Husbands' Characteristics		
<i>Characteristics</i>	<i>Frequency</i>	<i>Percentage</i>

Figure 1: Covert Contraceptive among the Respondents

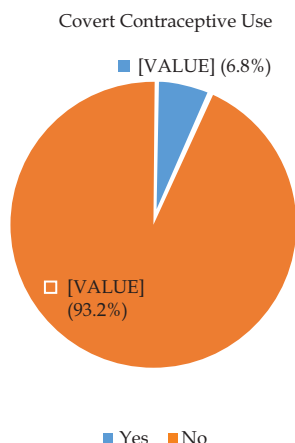


Table 2: Analysis of motivation of covert contraception as related to age, parity, occupation.

		Total N=365	Covert Contraceptive Use n=25	Non-Covert Contraceptive Use n=340	p≤0.05
Age	20-30 years	104 (28.5%)	8 (32.0%)	96 (28.2%)	0.555
	31-40 Years	191 (52.4%)	13 (52.0%)	178 (52.4%)	
	41-50 Years	67 (18.4%)	4 (16.0%)	63 (18.5%)	
	> 50 years	03 (0.8%)	0(0.0%)	03 (0.9%)	
Parity	0 child	01 (0.27%)	0(0.0%)	01(0.3%)	0.385
	1 child	23 (6.3%)	2(8.0%)	21(6.2%)	
	2 children	64 (17.5%)	5(20.0%)	59(17.4%)	
	3 children	108 (30.0%)	8(32.0%)	100(29.4%)	
	4 children	100 (27.4%)	8(32.0%)	92(27.1%)	
	≥5 children	69 (18.9%)	2(8.0%)	67(19.7%)	
Religion	Muslim	148 (40.5%)	13(52.0%)	135(39.7%)	0.642
	Christianity	217 (59.5%)	12(48.0%)	205(60.3%)	
Education	None	10 (2,7%)	03(12.0%)	07(2.1%)	0.679
	Primary	105 (28.8%)	06(24.0%)	98(28.8%)	
	Secondary	172 (47.1%)	12(48.0%)	160(47.1%)	
	Tertiary	78 (13.2%)	04(16.0%)	74(21.8%)	
Occupation	Trading	231 (63.3%)	16(64.0%)	215(63.2%)	0.926
	Civil Service	33 (9.0%)	05(20.0%)	28 (8.2%)	
	House wife	5 (27.4%)	01(4.0%)	92(27.1%)	
	Others	96 (26.3%)	3 (12.0%)	93 (27.4%)	
Husbands' Education	None	8(2.2%)	1(4.0%)	8 (2.4%)	0.926
	Primary	40 (11.0%)	4(16.0%)	36 (10.6%)	
	Secondary	194 (53.2%)	14 (56.0%)	180 (52.9%)	
	Diploma	59 (16.2%)	4(16.0%)	55 (16.2%)	
	First degree	44 (12.1%)	2(8.0%)	42 (12.4%)	
Higher Degree	20 (5.5%)	0 (0.0%)	20 (5.9%)		
Total		365 (100.0%)			

Table 3: Analysis of covert contraceptive use as related to husband's approval and financial support

Characteristics	Total	Covert Contraceptive Use	Non-Covert Contraceptive Use	p≤0.05
Husbands Approval of Contraceptive Use				
Disapproved	25 (6.98%)	18(72.0%)	7(2.1%)	0.000
Indifferent	19 (5.21%)	5(20.0%)	14(4.1%)	
Approved	321 (87.94%)	2(8.0%)	319(93.8%)	
Husbands Financial Support				
No Support	14 (3.56%)	8(32.0%)	6(1.8%)	0.000
Some Support	60 (16.43%)	6(24.0%)	54(15.9%)	
Full Support	291 (79.72%)	11(44.0%)	280(82.3%)	

DISCUSSIONS

The prevalence of covert contraception in this study was 6.8% is similar to findings in the early studies in many Sub-Saharan Africa settings^{6,7,8}. However, the prevalence report of this study does not agree with the more recent findings where the prevalence ranges between 26% to 47%.⁷The observed differences in prevalence these studies might be related to a number of factors which will include differences in methodological approaches used in the different studies, lack of a standard definition for covert contraceptive use and differences in methods of obtaining information⁶. Contraceptive practice is associated with a strong socio-cultural norm that lack of consensus approach will introduce a wide range of variations as seen in these studies.

The mean age of the participants in this study was 34.7±13.34 years with most of the women between the ages of 31-35years (26.6%). This mean age from our study is slightly higher than finding from similar study in Adama town, Addis Ababa, Ethiopia where the mean age was 28.2±6.8years and most participants were in 25-34years range.⁶ This difference may be explained by prevalent early marriage which characterise Ethiopia. In many low- and middle-income countries socio-cultural beliefs encourage marriage at a young age, usually shortly after the girls' first menstrual period.⁹

Majority of the women who participated in this study were at least Senior Secondary School

Certificate holders with a percentage of 48.7%. This might account for the relatively lower covert contraceptive use among these participants. Education is an important determinant of health practices and outcomes. Higher levels of education have been associated with improved reproductive health services uptake.¹⁰ Education promotes interspousal communication on reproductive health issues like family planning.^{11,12}

In our study, women who had no formal education had the highest level of practice of covert contraception (30.0%) and no woman who had higher degree practiced covert contraception. Education promotes women empowerment to enable them easily discuss issues relating to their reproductive health with their husbands without any fears of intimidation by the husband, have control over their reproductive health issues or over the number of children and when to stop child bearing. All these will result in less covert contraceptive use. This may also explain why no woman with higher degree qualification practiced covert contraception

In many developing countries, access to lifesaving health services is limited among with low socioeconomic status.^{13,14} Husbands' financial support for their homes was found to play a major role in covert contraception use in this study. Majority of women who described their husband's financial support as 'bad' practiced

covert contraception. Lack of spousal support, especially financial, predicts poor outcomes for a number of reproductive health issues. In women, this association is stronger. Women with unsupportive spouses, financially, are known to experience greater marital stress compared with women whose husbands supported them in their health-related struggles.¹⁵ In addition, husband's approval of family planning has been found to contribute significantly to the practice of covert contraception.¹⁶⁻¹⁸ This was demonstrated in this study in that 88.5% of respondents who described their husband's approval of family planning as bad practise covert contraception while none of those who described husband's approval as good and excellent practiced covert contraception.

The effect of increase in the number of children delivered by a woman in relation to the practice of covert contraception rises along the curve, plateaus and then starts dropping (Table 2). This may be explained by the fact that both the woman who has a high number of children and her husband already have obvious reasons to plan their families due to the pressing financial demands of taking care of the children as the husband is likely to support the wife's decision for contraception.¹⁹

Occupation has been shown to have a significant impact on the practice of covert contraception.²⁰ Findings from our study, though not statistically significant, showed that 20.0% of the civil servants who are likely gainfully employed because of their educational attainment practiced covert contraception compared with 4.0% of unemployed, housewives. The dependent status of such unemployed makes them vulnerable and inability to discuss or negotiate a number of issues that bothers on their health like contraception resulting to covert use option. However, we also find that 64.0% of the traders practiced covert contraception. This might also be related to financial empowerment and possible associated decision liberty.

A relationship has also been found between the level of education of the husband and the practice of covert contraception by the wife. From our study the more educated the husbands, the lower the possibility of the wives practicing covert contraception. This finding agrees with other studies in which greater interspousal

communication on family planning where observed in those with husbands' higher educational degrees, hence very low practice of covert contraception.^{12,21} It can be inferred from this study that interspousal communication on family planning increases with increase in the level of education of the husband and with increased interspousal communication, the practice of covert contraception declines.

In conclusion, this study has shown that covert contraception use by women exist, though at a relatively common rate, in our environment as shown by other earlier studies in Nigeria^{22,23}. The main factors promoting the practice in our environment are poverty, poor spousal financial support, illiteracy, unemployment and husband's disapproval of family planning use. These highlight the need for women's empowerment, reproductive health-related discussions among couples, promotion of greater male involvement in reproductive health services in our setting as in many other low-income countries.

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