Obstacles to contraceptive adoption amongst women in union in low contraceptive practice settings in sub-Saharan Africa: the case of the Republic of Benin

Background: The new investment framework in family planning (FP) in developing countries is one of the most effective interventions to guide national health and development planning by decreasing numerous unintended pregnancies, the cause of unsafe induced abortions with its associated risks for mother and infant mortality (Joshi, 2009). Gaining access to FP services improves maternal and child health outcomes, and affords women more opportunities to become economically active (Blue Ventures, 2015). Despite efforts and commitments to improving the use of contraceptives, the rate at which people use contraceptives in Benin Republic remain low (modern CPR=9% in 2011/2012) even though the knowledge of contraception is widespread in most parts of the country, the knowledge of each method being 85% (INSAE & ICF, 2013). It has been noticed over time, that there is a weak appropriation of the use of contraceptives especially among married or in union women; the rates of increase are low: modern CPR which is already low, has increased by only 2 points in a decade that is from 6.7% in 2001 to 8.8% in 2011/2012. There is then a need for more understanding of the barriers behind contraceptive uptake among women who are married or in union.

Main question and hypothesis: Findings from quantitative analysis from past studies in Benin Republic (Dansou, Adekunle, & Arowojolu, 2017) clarified the determinants of contraceptive practice and suggested the need for qualitative studies for more understanding of the barriers undermining contraceptives uptake among Beninese women living in union / marriage. The present studies attempts to fill such gap in order to provide policy makers with practical and key recommendations for future interventions with the ultimate goal of improving contraceptive uptake among married women.

Methodology: Data were gathered from in-depth interviews (93 KII) of participants from various backgrounds (reproductive age women, men, fathers in-law, and mothers in-law, representatives of community based associations, representatives of NGOs specializing in RH, health workers, religious leaders including endogenous leaders) and focus groups discussion (12 FGD). Data collection were conducted between January and April 2017 across the country: northern, southern and center where one urban and one rural area were investigated in each region. A total of 199 participants were interviewed using in-depth interviews and focus group discussion guides. Ethical approval was obtained from "Comité National d'Ethique pour la Recherche en Santé (CNERS) of Benin before the study was carried out.

Transcription of notes from the tape recording of the discussions and interviews was performed. The transcriptions were carefully compared with notes taken during data collection, and a final comprehensive list of the ideas raised by the respondents, then examined and categorized according to the main purpose of the study. Afterwards, they were divided into categories of similar responses according to the study goals. Lastly, the content analysis of records

was done highlighting factors which help to understand underlying logics and barriers undermining FP of use.

Key results:

Demographic Characteristics of Study Participants

Table 1 showed the demographic characteristics of study participants. A total of one hundred and ninety-nine (199) individuals were involved in the qualitative study among which ninety-three were (93) in in-depth interviews while one hundred and six (106) through twelve (12) focus groups discussion. Among them were 102 men and 97 females, out of which 107 respondents dwelled in urban areas.

Table 1 : Demographic Characteristics of Study Participants

	In-depth Interviews (n = 93)			**Focus Group Discussion (n = 106) 12 FGD**			**Total**
	Southern (n =31)	**Centre (n =32)**	**Northern (n =30)**	**Southern (n = 34) 4 FGD**	**Centre (n =37) 4 FGD**	**Northern (n =35) 4 FGD**	
Age groups (years)							
< 30	05	04	06	11	22	11	**59**
30 – 44	09	09	12	21	12	19	**82**
45 +	17	19	12	02	03	05	**58**
Sex							
Male	17	20	16	16	17	16	**102**
Female	14	12	14	18	20	19	**97**
Place of Residence							
Urban	15	14	13	16	16	18	**92**
Rural	16	18	17	18	21	17	**107**

Source: Author's Computation

Traditional and cultural beliefs continue to shape the reproductive life of Beninese. Among others, cultural and religious beliefs emerged as important barriers for family planning use. Communities' influence especially partners and family in-law's roles also emerged. Health workers' attitudes towards health service users and side effects of contraceptives were also reported by many participants as an important deterrent for not using FP. Religious leaders also disapprove of family planning. The main reason remains that family planning use is against the

law of the creator. Moreover, talking and advising people in churches and mosques to access and adopt family planning is like pushing them especially women and young girls into prostitution and fornication. Family planning according to some religious leaders may, to some extent be adopted by married women only for birth limitation. For some participants, family planning is the business of unmarried and especially separated/divorced women who are afraid of having unclaimed pregnancies. In short, they adopt family planning just to meet their sexual needs the moment they are out of marriage/union.

This is a point of view of a religious leader:

"*In Catholic Church, we disapprove of FP because we noticed that women and girls know that by adopting FP they are free in their movements especially sexually relationships. Girls in particular get into fornication and prostitution and married women in extra-conjugal sexual relationships…. Therefore, talking about family planning in churches is like encouraging this phenomenon….*" (Leader Christian religion in in-depth interview, Bembèrèkè).

A mother in-law in in-depth interview expressed her perceptions of and attitudes to family planning practice:

> *"It is religion that interdicts family planning practice. In addition, contraceptives are a source of problems for female users. They experience many difficulties when they stop using contraceptives: conception issues, multiple menses within a month, add unnecessary weight…"* (Mother-in-law in in-depth interview, Djougou).

Many other participants have given similar testimonies pertaining to religious barriers and side effects of contraceptives as reasons for their negative perceptions towards these services.

Side effects of contraceptives also emerged as key barrier. A retired midwife expressed some obstacles (pertaining to side effects and cost of services) to using reproductive health services in her community:

> *"Among other difficulties to family planning, I can list the side effects of contraceptives…."* (Retired midwife in in-depth interview, Djougou).

Difficulties in procreation after use, multiple menstrual periods a month, and weight gain emerged as the main side effects of using contraceptives as reported by some participants:

> *"I can cite the example of a sister of mine who had conception difficulties after FP. Also, a friend of mine lost her menstrual cycle as a consequence of using contraceptives. Another friend experienced perturbations with her menstrual cycle after FP: her menstrual cycle has turned twice a month."* (Mother in a focus group discussion, Djougou).

The side effects of contraceptives which women experience and the negative rumours surrounding them negatively affect men in deciding for or against family planning. It was discovered that men's decisions on family planning issues are weakened by its side effects on some of the females using contraceptives. Indeed, some men, even with a positive attitude toward FP are afraid of talking about contraception with women including their spouses. For them, recommending that a woman uses contraceptives is perceived as a punishment because of the related negative effects. Some men are, therefore, afraid of how their partner will react to their advice or decision on using contraception since they are both aware of the side effects of using contraceptives.

Conclusion and policy implications

The study's findings revealed leading barriers undermining contraceptive uptake among women in union/married and gave more insights into the way forward for enhancing access to and the use of FP even in extended postpartum period. Among them, there is a need:

- ✓ To move beyond individual women in interventions to improve women's use of reproductive health services to target different stakeholders at multiple levels including husbands, in-laws, family, and community leaders including religious leaders, for an effective and positive outcome.
- ✓ To strengthen actions to address health providers' poor attitudes toward health service users. Result based-financing initiative was discovered with great positive impact on the matter which needs strengthening to be effective and in place everywhere across the country.
- ✓ To financially support or take a complete charge of users experiencing side effects of contraceptives.
- ✓ To address cultural and religious barriers by strengthening sensitization campaigns for people in remote areas especially where most inhabitants still rely on their experiences of culture and traditions which do not always guaranty a good health outcome.
- ✓ To make FP services physically close to people and services available especially in remote areas where challenges are greater and current services minimum.
- ✓ To create and increase users' awareness about all aspects of reproductive health services including the side effects of these services. People need to know about all aspects of services and even the worst outcomes they may experience in using services.