# Psychosocial Consequences and Women Experience of Using Contraceptives in Temeke Municipality, Tanzania.

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***Ikisiri***

*Msingi wa haki za wanawake na wasichana, pamoja na afya zao za uzazi, ni upatikanaji wa njia salama na za kisasa za uzazi wa mpango. Uhuru wa wanawake, uhuru, na usawa wa kijinsia vyote vinategemea upatikanaji wa upangaji sahihi uzazi. Utafiti huu ulijikita katika tathmini ya athari za kisaikolojia na kijamii wanazopata wanawake kutokana na kutumia vidhibiti mimba katika Manispaa ya Temeke, Tanzania. Utafiti ulitumia muundo wa kifani ambapo sampuli ya ukubwa wa wanawake 306 wanaohudhuria huduma za uzazi wa mpango katika Hospitali ya Mbagala Rangi Tatu walitumika katika kutoa taarifa kwa njia ya dodoso na mahojiano. Matokeo yalifichua athari kadhaa hasi na chanya kama vile mabadiliko yasiyo ya kawaida ya mara moja, hisia za hatia na aibu, huzuni, hisia za kukata tamaa, mabadiliko yasiyo ya kawaida ya mifumo ya kulala, na kadhalika, huku madhara chanya yalijumuisha furaha na hakuna majuto kati ya wengine. Pamoja na hayo utafiti ulibainisha wanawake wengi kuwa na hisia hasi juu ya matumizi ya njia za kuzuia mimba.*

## Abstract

*The cornerstone of women's and girls' rights, as well as their sexual and reproductive health, is access to safe and modern contraceptives. Women's independence, freedom, and gender equity are all aided by access to family planning. This study focused on the assessment of the psychosocial consequences that women experience as a result of using contraceptives as well as their perception on the use of contraceptives in Temeke*

*Municipality, Tanzania. The study employed a case study design whereby a sample size of 306 women attending contraceptive services at MbagalaRangiTatu Hospital were used in providing data from questionnaire and interviews. Findings revealed several negative and positive side effects such as immediate abnormal changes, feelings of guilt and shame, depression, feelings of hopelessness, abnormal changes in sleeping patterns, and the like, while positive side effects included happiness and no regrets among others. In addition, the study found that most of women had negative perception on the use of contraceptives. The study concluded that the use of contraceptives has both negative and positive effects to women. It is thus recommended that family planning programs should focus on increasing men's approval of contraception, improving partner communication around family planning and bolstering women's confidence in their reproductive decision making.*

**Keywords:** Psychosocial consequences, contraceptives; family planning, perception

## 1.0. INTRODUCTION

Education, sexuality, age, marital support, parity, access to family planning facilities, social policy, and moral, cultural, and religious beliefs all influence the usage of contraceptives such as injectable contraceptives, oral contraceptive tablets, condoms, and intra-uterine contraceptive devices (Killick, 2005; Van Lunsen, Van Dalen, &Laan, 2006; Welling, 2013). Promoting women's, girls', and couples' access to preferred contraceptive methods is critical for ensuring women's well-being and autonomy while also helping community health and development. Age, education, and socioeconomic level are all common factors of contraceptive use (Khan, Mishra, Arnold, &Abderrahim, 2007).

Numerous studies in Europe and the United States, according to Rosenberg, Waugh, and Meehan (1995) and Rosenberg, Waugh, and Meehan (1998), highlighted causes for contraceptive discontinuation, with a particular focus on unpleasant side effects. When compared to women who did not experience unfavorable side effects, those who experienced negative side effects were nearly twice as likely to discontinue using the pill while still at risk of unwanted pregnancy. A change in fertility desires is another typical reason for discontinuing contraception use. Changes in partner relationships are more

prevalent, and this can be especially problematic when sexual activity restarts before contraception use resumes (Westhoff, 2005).

In Denmark, Tello (2016) reports on a study conducted between 2000 and 2013 with over a million Danish women (aged 15 to 34) utilizing hard data such as diagnosis codes and prescription records, which clearly implies that all types of hormonal contraceptives are related with an elevated risk of depression. The data showed that all types of hormonal contraceptives were linked to an elevated risk of depression, with progesterone-only versions, such as the intra-uterine contraceptive devices, having the highest risks.

Contraception use is much lower in underdeveloped countries than in other areas of the world. Contraceptive use was significantly lower in the least developed countries (at 40%) and particularly low in Africa until 2015, according to a report published by the United Nations Department of Economic and Social Affairs, Population Division (at 33 percent). In 2015, the proportion of women who wanted to use contraception but couldn't (unmet need for family planning) was substantially greater in the least developed nations (at 22%), with many contributing countries belonging to Sub-Saharan Africa, where the unmet need was twice the worldwide average. According to certain studies, only a small fraction of sexually active women in developing countries utilize modern contraception, such as oral contraceptives and condoms (Anasel, &Mlinga, 2014; Bakibinga, Matanda, Ayiko, et al., 2016; & Williamson, Parkes, Wight, Petticrew& Hart, 2009).In Zambia, Ashraf, Buessing, Field, andLeight(2014) revealed that changes in contraceptive use are driving the improvement in mental health. In the analysis, the estimates showed that improved access to birth control had a positive effect on almost all of the indicators. Their findings imply that increasing contraceptive access has an immediate impact on women's psychosocial health, even if reproductive impacts are minor or have not yet manifested.

Despite high contraceptive awareness (90.2 percent, 95.0 percent, 99.3 percent, 98.0 percent, and 98.2 percent in Burundi, Kenya, Rwanda, Tanzania, and Uganda, respectively), there are considerable disparities in contraceptive access and quality across the East African region (Bakibinga, et al., 2016).These degrees of contraceptive awareness are all considered universal. Despite the fact that contraceptive awareness is nearly universal, Bakibinga, et al.

(2016) show that contraceptive prevalence in the region has increased over the last two decades. As a result, Burundi, Kenya, Rwanda, Tanzania, and Uganda, five East African countries, had made extraordinary progress in reproductive, maternal, newborn, and child health as of 2015. Contraceptive prevalence rates have increased significantly in Rwanda, from 21.2 percent in 1992 to 51.6 percent in 2011, in Kenya, from 32.7 percent in 1993 to 58 percent in 2014, and in Tanzania, from 7% in 1991-92 to 32% in 2015-16. (Bakibinga, *et al*., 2016).

In Tanzania, implants, male and female sterilisation, oral contraceptive pills, progestogen-only injectables, intrauterine device - copper containing only (IUCD), male and female condoms, and emergency oral contraceptive pills are among the modern contraceptive methods allowed for use in Tanzania (Sedekia, Jones, Nathan, Schellenberg, & Marchant, 2017). Short-acting methods of family planning remain the most popular: currently married women are more likely to use injectables (11%) or pills (7%), whilst sexually active unmarried women choose male condoms (16%) and injectables (15 percent) (Sedekia *et al*., 2017).

Research on the psychological consequences of contraceptive use and managed fertility has mostly ignored the psychosocial consequences. The majority of research has focused on real or perceived physical side effects that limit contraceptive use (Anasel&Mlinga, 2014; Williamson et al., 2009). Furthermore, the Tanzania Demographic and Health Surveys lack items that would allow for an investigation of the link between reproductive activity and psychosocial consequences as well as the women perception on the use of contraceptives. As a result, the psychosocial implications of contraceptive use among women and their perceptions were examined in this study.

## 2.0. MATERIAL AND METHODS

### 2.1. Research Design

Kothari (2004) describe the main purposes of the research design are to make the researcher's decision explicit; ensure that the decisions are consistent with each other; allow for critical evaluation of the individual design elements, and the overall research design, before significant work commences. This study followed a case study design. It is a case

study because it focused on one unit of subjects (one hospital) while leaving others (other hospitals) in the same geographical area. In addition, the design was chosen because of its robust in terms of saving time as well studying an aspect completely in depth and accurately using minimal resources (Wario & Khalfan, 2015).

### 2.2. Study area and Target Population

This study aimed to generalize its data to all women who received contraceptive or family planning services at MbagalaRangiTatu Hospital. The Reproductive Services Clinic at MbagalaRangiTatu Hospital serves an average of 50 women a day; equivalent to serving a maximum of 1,500 women per month and 18,000 women per year. The researcher took a monthly population i.e. 1,500 as the permanent target population because clients of reproductive services did not form a permanent population; women came and went, and their return was not guaranteed. Given this reality, the sample size was determined using non-probability sampling procedures.

### 2.3. Sampling Procedure

This study employed a non-probability sampling technique namely purposive sampling.Purposive sampling was used in the sense that for a woman to be selected for participation, two major criteria had to be met: (1) a woman had to be residing in Temeke Municipality (the study area) and (2) a woman should have used contraceptive services for at least one year as a reasonable period for side effects of contraceptives on fertility to be realized.

### 2.4. Sample Size

In this study, the sample size was derived from the monthly population of women attending contraceptive services at MbagalaRangiTatu Hospital i.e. 1,500. Krejcie and Morgan (1970) formula for sample size was used to compute the required sample size for the study. Hence, 306 women attending contraceptive services at MbagalaRangiTatu Hospital constituted the sample size of this study.

### 2.5. Data Analysis

In this study both quantitative and qualitative analytical procedures were used to analyze data. The specific analytical procedures for quantitative data analysis constituted statistical measures namely frequencies, percentage distributions, and mean and standard deviation counts. Computations of scores on questionnaire responses answering the first objective of study (to assess the psychosocial consequences that women experience as a result of using contraceptives in Temeke Municipality, Tanzania) were done using IBM SPSS Statistics (Version 20). The presentation of data was made using Tables. While for qualitative data analysis for the second objective of the study (to assess the perception of women on the use of contraceptivesin Temeke Municipality, Tanzania) was analysed by using thematic analysis.

## 3.0. RESULTS AND DISCUSIONS

### 3.1 Demographic Profile of Respondents

**Table 1: Demographic profile of respondents**

| **Age groups** | **Frequency** | **Percentage** |
|---|---|---|
| 18 -25 years | 109 | 36% |
| 26 – 35 years | 142 | 46% |
| 36 - 45 | 55 | 18% |
| Total | 306 | 100% |
| **Education qualification** | **Frequency** | **Percentage** |
| Standard Seven | 73 | 23% |
| Ordinary secondary level | 145 | 47% |
| Advanced secondary level | 36 | 12% |
| Diploma | 12 | 4% |
| Bachelor degree | 37 | 12% |
| Postgraduate diploma/ degree | 3 | 1% |
| **Total** | **306** | **100%** |

| **Age groups** | **Frequency** | **Percentage** |
|---|---|---|
| **Religion** | **Frequency** | **Percentage** |
| Muslim | 197 | 64% |
| Christianity | 109 | 36% |
| Other | 0 | 0% |
| Total | 306 | 100% |
| **Number of Children they have** | **Frequency** | **Percentage** |
| 1 – 2 children | 82 | 26% |
| 3 – 4 children | 204 | 67% |
| 5 and above | 20 | 7% |
| **Total** | **306** | **100%** |

According to Table 1, out of the 306 women involved in the study 109 (36%) were between 18 and 25 years, 142 (46%) were between 26 and 35 years while only 55 (18%) were 36 and 45 years. This implies that the majority of respondents (i.e. 46%) were in their middle adulthood stage. The remained age groups (64%) were middle adults and below. Hence, the researcher observed that this age group fits the study because they belong to the group of women who are either seeking to add more children or planning to have a family size that they can be able to provide for all the basic needs. So generally, this age group provided rich information that the researcher was looking for and through such information the researcher managed to assess the psychosocial consequences that women who use contraceptives face, with a focus on women receiving contraceptive services at MbagalaRangiTatu Hospital in Temeke Municipality.

Regarding education level, out of the 306 respondents, 73 (23%) were holders of ordinary standard seven certificate, 145 (47%) had attained ordinary secondary level certificate, 36 (12%) had advanced level certificate, 12 (4%) were holders of diploma, 37 (12%) had bachelor degree and only 3 (1%) had postgraduate diploma/degree. The findings indicate that the majorityof respondents were holders of secondary school qualification, (i.e. 47%) while 233 (77%) were holders of secondary school certificate and above. Findings imply

that the holders of ordinary secondary school qualifications and above dominate the study findings on the use of contraceptives. Hence, the researcher observed that, this group (holders of secondary school certificate and above) had enough knowledge on the use of contraceptives and their contribution to the study findings was vital.

Regarding religion, 197 respondents (64%) were Muslims and 109 (36%) were Christians. This implies that majority of the respondents involved in this study were Muslims by religion. However, the researcher observed that despite the fact that religion is important in one's spiritual life and today religion is considered as a part of someone's' culture, in this study religion category was not observed as the factor that affected the findings of this study.

On the number of children, out of 306 respondents involved in the study, 82(26%) had 1-2 children, 204(67%) had 3 – 4 children while 20(7%) had 5 children and above. Cumulatively the findings indicates that majority of the respondents 204(67) had 3 - 4 children. Hence, the researcher observed that, most of women preferred to have children ranging from 3 to 4 only. This implies that such a number is affordable for most of families who believe that they can afford to provide the needed basic needs such as food, education and the like.

### 3.2. Negative and positive psychosocial effects of women experience as a result of using contraceptives.

To interpret the mean scores the following values and interpretation were utilized.

**Table 2: Mean scores interpretation**

| Mean Range | Description | Interpretation |
|---|---|---|
| 3.26-4.00 | Strongly Agree | Very High |
| 2.51-3.25 | Agree | High |
| 1.76-2.50 | Disagree | Low |
| 1.00-1.75 | Strongly Disagree | Very Low |

**Table 3: Negative and positive psychosocial effects women experience as a result of using contraceptives (n=306)**

| Item | Mean | Std. deviation | Interpretation |
|---|---|---|---|
| **Negative** | | | |
| Immediate abnormal changes in my body | 3.19 | 0.55 | High |
| Feelings of guilt and shame | 3.19 | 0.60 | High |
| Being in a down or distressed mood | 3.17 | 0.44 | High |
| Feelings of hopelessness | 3.14 | 0.51 | High |
| Experiencing increased changes sleeping patterns | 3.13 | 0.45 | High |
| Changes in appetite | 3.13 | 0.59 | High |
| Experiencing exhaustion or extreme tiredness | 3.12 | 0.58 | High |
| Weight gain | 3.09 | 0.66 | High |
| Nausea | 3.08 | 0.45 | High |
| Negative treatment from your husband | 3.05 | 0.51 | High |
| Feeling of stress | 3.01 | 0.50 | High |
| Dizziness | 2.97 | 0.66 | High |
| Worry and anxiety | 2.94 | 0.75 | High |
| Fear of stigma | 2.93 | 0.67 | High |
| Anger | 2.90 | 0.68 | High |
| Abnormal pain | 1.89 | 0.94 | Low |
| **Sub-total** | **3.00** | **0.60** | **High** |
| **Positive** | | | |
| contributed to the quality of your relationship | 3.04 | 0.69 | High |
| Increased my time to socialize with peers | 2.93 | 0.62 | High |
| Facilitate opportunities to engage in community | 2.87 | 0.64 | High |
| Removed expected interruptions making me stable | 3.02 | 0.59 | High |
| Feel empowered to pursue my personal goals | 3.00 | 0.61 | High |
| Associate positive feelings with my being on birth | 2.92 | 0.62 | High |
| Feel much better than before since I started | 2.91 | 0.68 | High |
| Increased sense of self-worth | 2.88 | 0.69 | High |
| Feel much happier than before | 2.88 | 0.69 | High |
| Have no regrets on contraceptive use | 2.31 | 0.95 | Low |
| **Sub-total** | **2.86** | **0.67** | **High** |

According to the study findings in Table 2, respondents rated themselves high implying that they agreed on immediate abnormal changes in body (mean = 3.19, std. deviation = 0.55) and feelings of guilt and shame (mean = 3.19, std. deviation = 0.60). This is reflecting the women's perceived consciousness of what their respective communities, families and cultures consider to be respectable in relation to contraceptive use.

With regards to being in a down or distressed mood, respondents also rated themselves high (mean =3.17, std. deviation =0.44) implying their agreement on that effect. Feelings of hopelessness and experiencing increased changes sleeping patterns were also rated as high with sums of (mean= 3.14, std. deviation = 0.51), (mean=3.13, std. deviation= 0.45) respectively. This is indicative of the different and negative hormonal effects contraceptive can have on women.

Respondents agreed on changes in appetite which was high (mean =3.13, std. deviation =0.59). High ratings were also reported in relation to exhaustion or extreme tiredness (mean=3.12, std. deviation =0.58), weight gain (mean=3.09, std. deviation =0.66), and nausea (mean=3.08, std. deviation =0.45). This not only highlights the psychological effects of contraceptive use on women, but also underscores the importance women attach to body image.

Negative treatment from husband (mean=3.05, std. deviation =0.51), feeling of stress (mean=3.01, std. deviation =0.50), dizziness (mean=2.97, std. deviation =0.66), worry and anxiety (mean=2.94, std. deviation =0.66), and fear of stigma (mean=2.93, std. deviation = 0.67) and anger (mean = 2.90, std. deviation = 0.68)were other negative feelings that received high ratings amongst the women implying their agreement on such effects.

However, on the other hand, respondents rated themselves low on abnormal pain (mean = 1.89, std. deviation = 0.94) implying their disagreement on that effect. This suggests that despite experiencing negative experiences as a result of contraceptive use, an extreme negative emotion such as pain was not commonly felt.

The above findings correspond with those of Rahnama et al., (2010) who highlighted weight gain, amenorrhoea, irregular and heavy bleeding, unwanted vaginal wetness and

dryness, pain and lower libido among others to be the effects of the use of several family planning methods. Additionally, the findings of Tello (2016) strongly suggest that there is an increased risk of depression associated with all types of hormonal contraceptive.

With regards to positive feelings, a high number of women reported that contraceptive use contributed to the quality of their relationships (mean=3.04, std. deviation =0.69). Further positive feelings that were rated as high included increased time to socialize with peers (mean = 2.93 std. deviation =0.62). Opportunities to engage in community activities was also given a high rating (mean=2.87, std. deviation =0.64). This intimates that contraceptive use has not only given women more freedom, but has also enabled them to proactively structure their time thus allowing them to participate and partake more fully in social engagements. Indeed, the removal of expected interruptions making women stable in their work roles also received a high rating (mean=3.02, std. deviation =0.59) suggesting contraceptive use permits women to adhere to work commitments. Feeling empowered to pursue personal goals at (mean=3.00, std. deviation =0.61) was also rated high signifying women's appreciation of being able to focus more on issues they felt were of importance to them.Thefindings on contraceptive use contributed to the quality of their relationships agree with those of Cox, Hindin, Otupiri and Reindor (2013) in Kumasi, Ghana who found that the use of contraceptives improves relationship quality.

Positive feelings continued to be rated high where associating positive feelings with being on birth control methods was (mean=2.92, std. deviation =0.62), feeling much better than before since started practicing birth control (mean=2.91, std. deviation =0.68), increased sense of self-worth (mean=2.88, std. deviation =0.69), and feeling much happier than before (mean=2.88, std. deviation = 0.69).

A few women reported feelings of regret in relation to their contraceptive uptake (mean= 2.31, std. deviation =0.95.) This establishes a general picture and is indicative of the women's appreciation of contraceptive use and how it has positively impacted their lives. As Ashraf et al. (2014) indicated a significant improvement in mental well-being of women using contraceptives.

### 3.3. Interview findings

Participants were first asked if they had used contraception and then the type of contraceptive method was assessed by a 10-item multi-response question inquiring about the type of contraception used including: withdrawal method, condoms, oral contraceptive pills, intrauterine device, sponge, female condom, vaginal ring, diaphragm, contraceptive patch, and subdermal implant. Second, participants were asked to explain the negative and positive psychosocial effects of women experience as a result of using contraceptives. Below is the summary of interview findings;

Knowledge and understanding of contraceptives were low; while most women knew different methods were available, there were many misconceptions. One of the interviewees said "… *Ibelieve that certain contraceptives cause death, infertility and side effects, contributed to fear of use….so for my side I do not use such things completely…"* This lack of knowledge and fear, even with the desire to space and limit births, affected motivation to use contraceptive. Hence these findings are against McGuire and Stephenson (2015) who insisted on the provision of knowledgethrough educational attainment of women, and provision of awareness regarding community and societal norms related to marriage and childbearing, as well as allowing women participation decision-making and contraceptive use which helps to address the need for family planning.

Religious affiliation of respondents in the study was noteworthy with regards to contraceptive use, with those of the Muslim faith tending to have larger families compared to their counterparts (Christians). One of the interviewee said *"…my faith does not allow me to use, though I use quietly even my husband does not know…"* Studies have found that women affiliated with Muslim faith were less likely to use contraceptive because of the faith's viewpoint on conventional methods of family planning, preferring traditional methods. These findings correspond with those of Budhwani, Anderson and Hearld (2018) in America who found that general Muslim and those identified as Sunni and Shia Muslim were significantly associated with greater odds of using contraception due to their faith and negative perception on the impact of contraceptives.

In the study, social support differed depending on parity, and women tended to feel pressure to restrict contraceptive use in the early stages of their fertility. Contraceptive use was significantly higher amongst women who had children, compared to those who didn't have any.

One interviewee said *"... in my tradition we are proud of having many children, if I have one or two like modern girls, I will become a mockery in my family...."* This symbolizes thatthe traditional status of women in the community is strongly tied to their fertility and that the higher the fertility, the higher the status in the community. This being the fact, in Tanzania some tribes stand against modern contraceptive use, therefore, reluctantly is accepted because it was believed to negate the traditional family values. These findings correspond to those of Ochako et al., (2015) who pointed out that there is misconceptions in communities that result to women discontinued contraceptive use.

Another interviewee said *"...my target is to get at least 2 sons because my mother in law wants them, I already have 4 daughters but my family is on my neck because they need a son... the reason why I use contraceptives behind my husband back is because I am not sure if my family will be able to take care of all my children...we are not that rich, as you can see after here I have to go back to school – Am actually a primary school teacher and I believe you know how much teachers here are paid!... we cannot afford to provide for more than even 3 children...imagine I have four while my family need six... it is very stressing please let me go..."* basing on this, the study observed that some families dictates women in terms of fertility and sex of children, minimal attention is afforded to how the women feel in terms of positive or negative emotions, financial independence, self-worthiness, and being able to take care of the already existing children. The potential of both the wives' and husbands' education in increasing contraceptive use has been reported by (Ahsanuzzaman, 2016).

Employment status is a factor significantly associated with current contraceptive use with women feeling more economically empowered giving them a positive feeling of increased self-worth (Stephenson, Beke and Tshibangu 2008). One of the interviewees said *"...my family is happy because I only have two children who my husband and I can afford to*

*provide for them…trust me dear even if today or tomorrow my husband dies, I can 100% afford to run my family… I have my job and my small businesses that make me very comfortable to keep it up with my contraceptive use…"*

Another interviewee said *"…it is hard to understand but my first girl is now 18 years old but I told her to start taking pills to avoid pregnancy…. You think it's foolish eeh! but I believe my decision helps in increasing labor force participation among women who first started to have access to the pill as they turned 18…".* The findings provide a new picture that some women allows their children to have knowledge on the use of contraceptives so that they can serve as assert in labor force and hence they directly become contributors in economic development.These findings are corresponding to the study by Hafez (2014) who pointed out that communities with high fertility rate could have many problems that harm not just the women but also children and families, affecting their quality of life and impeding long-term economic and social development.

Another interviewee added *"…most of us are ignorant and un-educated, personally with my degree I know much about the use of contraceptives, believe me some of us knows but ignores contraceptive education…."*

Education levels also highly influenced contraceptive use. There was a strong association between education and contraceptive use. Poor knowledge of different contraceptive methods led to comparatively low use of contraceptives compared to higher use where there was more knowledge and awareness of the varieties available.

Generally, in appreciation of using contraceptive, women's' responses included feelings of being able to better exercise family planning with regards to spacing the number of children they wanted. They were also able to be more engaged in community activities in addition to interacting with their peers. Those that were self-employed were able to concentrate on their businesses. These findings are corresponding to those of Morse et al., (2014) who asserted that engaging women that have successfully used contraceptive as family planning advocates is a strategy that is not currently widely exploited but has potential for motivating younger women.

Furthermore, Ahsanuzzaman (2016) stated that the benefits of family planning include, but are not limited to: protecting the health of women and children by lowering high-risk pregnancies, unsafe abortion, giving sufficient time between pregnancies, and ultimately, reducing fertility. Also, improving women's educational and employment possibilities as well as their full involvement in society. Another benefit is that it protects reproductive rights while also lowering the risk of sexually transmitted diseases like HIV infection. Individuals and couples are given the freedom to determine the size of their family as a result of this process. Finally, it contributes significantly to poverty reduction.

## 4.0. CONCLUSION AND RECOMMENDATIONS

### 4.1. Conclusion

Based on the study findings, it should be noted that the use of contraceptives has both negative and positive effects to women. However, due to low knowledge and understanding as well as negative perception on contraceptives use, fear, faith based perceptions and traditions among other reasons, the majority of women involved in the study were not using contraceptive methods.

### 4.2. Recommendations

The study recommended that family planningprograms should focus on increasing men’s approval of contraception, improving partner communication around family planning and bolstering women’s confidence in their reproductive decision making. The study also recommended that periodic programs should be organized nationwide to educate individuals both married and unmarried, with the aim of providing education in addition to clarifying any ambiguities about modern contraceptive use and its effects. Religious leaders and educational institutions should be given an opportunity to create awareness on the positive effects of contraceptive use across the country. This will help towards eradicating negative perceptions against contraceptive use amongst women.

## REFERENCES

Ahsanuzzaman, A. (2016). Benefits and costs of sexual and reproductive health for Bangladesh.North South University, Dhaka, Bangladesh.http://www.copenhagenconsensus.com/sites/default/files/zaman_sexual_reproductive_health.pdf

Anasel, M. G. &Mlinga, U. J. (2014). Determinants of contraceptive use among married womenin Tanzania: Policy implication. African Population Studies Vol 28 no 2 Supplement.

Ashraf, N., Buessing, M., Field, E., &Leight, J. (2014). The psycho-social benefits of access tocontraception: Experimental evidence from Zambia.https://sites.duke.edu/ericafield/files/2014/09/Psycho-SocialBenefits_Aug2014.pdf

Bakibinga, P, Matanda, D. J, Ayiko, R, et al. (2016). Pregnancy history and current use ofcontraception among women of reproductive age in Burundi, Kenya, Rwanda, TanzaniaandUganda: analysis of demographic and health survey data. BMJ Open, 6:e009991.doi:10.1136/bmjopen-2015-009991

Cox, C.M., Hindin, M.J., Otupiri, E &Reindorf, R.L. (2013). Understanding couples'relationship quality and contraceptive use in Kumasi, Ghana. International Perspectiveson Sexual and Reproductive Health, 39(4):185–194, doi: 10.1363/3918513

Hafez, A. A. A. (2014).Factors affecting the family planning methods used by the currentlymarried women in rural Egypt. American Journal of Research Communication, 2(10), 324-341.

Khan, S., Mishra, V., Arnold, F., &Abderrahim, N. (2007). Contraceptive trends in developingcountries. DHS Comparative Reports No. 16. Calverton, Maryland, USA: Macro International.

Killick, S. (2005). Patterns of contraceptive use: cross-sectional surveys. In: Contraception andcontraceptive use. RCOG Press, London, pp. 88-97.

Kothari, C. R. (2004). Research methodology: Methods and techniques (2nd Ed). NewDelhi: Wiley.

Krejcie, R.V., & Morgan, D. W. (1970). Determining sample size for researchactivities. Educational and Psychological Measurement, 30, 607-610.

Morse, J. E., Rowen, T. S., Steinauer, J., Byamugisha J., &Kakaire, O. A. (2014). Qualitativeassessment of Ugandan women's perceptions and knowledge of contraception. Int JGynaecolObstet, 124(1): 30–3.

Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M. (2015).Barriers to modern contraceptive methods uptake among young women in Kenya: aqualitative study. BMC Public Health, 15(1): p. 1483.

Rahnama, P., Hidarnia, A., Amin, S. F., Kazemnejad, A., Ghazanfari, Z., &Montazeri, A.(2010). Withdrawal users' experiences of and attitudes to contraceptive methods: A studyfrom Eastern district of Tehran Iran. BMC Public Health. 10: p. 779.

Rosenberg, M.J., Waugh, M.S., Meehan, T.E., (1995). Use and misuse of oral contraceptives:risk indicators for poor pill taking and discontinuation. Contraceptive; 51:283-8.

Rosenberg, M., Waugh, M. (1998) Oral contraceptive discontinuation: a prospective evaluationof frequency and reasons. Am J ObstetGynecol; 179:577-82b.

Sedekia, Y., Jones, C., Nathan, R., Schellenberg, J., & Marchant, T. (2017). Using contraceptivesto delay first birth: a qualitative study of individual, community and health providerperceptions in southern Tanzania. BMC Public Health, 17(1), 768. DOI:https://doi.org/10.1186/s12889-017-4759-9.

Stephenson, R., Beke, A., &Tshibangu, D. (2008). Contextual influences on contraceptive use inthe Eastern Cape, South Africa, Health & Place, 14(4):841-852.

Tello, M. (2016). Can hormonal birth control trigger depression? Retrieved 20/05/2019 fromhttps://www.health.harvard.edu/blog/can-hormonal-birth-control-trigger-depression2016101710514.

United Nations, Department of Economic and Social Affairs, Population Division (2015). Trendsincontraceptive use worldwide 2015 (ST/ESA/SER.A/349). New York. United Nations.

Van Lunsen, R. H. W., Van Dalen, L. P., and Laan, E. T. M. (2006.) Contraception andsexuality. In: Contraception and Family Planning: Editor: Milsom I, European Practice inGynaecology and Obstetrics Series No.8, Elsevier, Edinburgh.

Wario, W., &Khalfan, A. (2015). Principles, methods and practices of social scienceresearch, Sumait University Press, Zanzibar.

Welling, L. L. M. (2013). Psychobehavioral.Evolutionary Psychology: www.epjournal.net, 11(3): 718-742.

Westhoff, C. (2005). Trends in sexual behaviour: In contraception and contraceptive use. RCOGPress, London pp. 108-117.

Williamson, L.M., Parkes, A., Wight, D., Petticrew, M., & Hart, G.J. (2009). Limits to moderncontraceptive use among young women in developing countries: a systematic review ofqualitative research. BioMed Central Ltd; Open access Journal. Reproductive Health, 6:3. doi:10.1186/1742-4755-6-3.