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Abandoning Contraception at the Commune V Reference Health Center in Bamako, Mali

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Abstract **Original Research Article**

***Introduction*:** A descriptive analysis of contraception discontinuation, based on Demographic and Health Survey data from six countries with high level of contraceptive use, fonds that approximately one-third of couples discontinuous their contraceptive use, method within 12 months and about half cease within 24 months. ***Aim*:** Was to study the reasons for abandoning contraception at the Reference Health Center of Commune V of District of Bamako. ***Material and Methods*:** We carried out a prospective, descriptive and cross-sectional study on the reasons for abandoning contraceptive methods from January 1, 2020 to December 31, 2020. ***Results*:** The frequency of abandonment of contraceptive methods in Commune V was 18.19%. The main reasons mentioned among the 200 former users of contraceptive methods interviewed were side effects with 35% of cases, husband's opposition (10 %), complications (20%), the desire to pregnancy (10%), reception of clients and occasional unavailability of inputs (5%). ***Conclusion*:** Inadequate management of side effects and complications related to contraception, the husband's reluctance and rumors had been the determining factors in the abandonment of contraception.

Keywords: Abandonment, Birth control, Commune V, Bamako, Mali.

INTRODUCTION

The current population growth and related problems are seen as an obstacle to the socio-economic development of developing countries. This situation is attracting increasing public attention. In recent years, controlling the natural movement of people has been an issue for the majority of governments in developing countries. In recent years, therefore, there have been behavioural changes in the use of modern contraceptive methods, thanks to family planning initiatives [1]. The introduction of modern contraceptive methods is a recent phenomenon in Mali. It follows the creation, in June 1972, of the Malian Association for the Promotion and Protection of the Family (AMPPF), a non-governmental organization, the reorientation of maternal and child health policy and the creation, in 1980, of the Division of Family and Community Health (DSFC) transformed in 2001 into the Reproductive Health Division (RSD) within the National Directorate of Health. Today it is clear that the health and quality of life of individuals improve, when they are able to decide on the number of their children. Mali's health policy has evolved and continues to evolve since the 1960s. With the financial and technical support of development partners, Mali has undertaken plans and programmes in the various socio-economic sectors. Reproductive health policy is part of these measures. The concept of reproductive health includes a set of preventive, curative and promotional measures aimed at improving the care of vulnerable groups such as women, children and young adults in order to reduce maternal, child and juvenile mortality and morbidity and thus promote the well-being of all individuals [2]. Mali's total fertility rate of 6.8 is one of the highest in the world and has not declined significantly in recent years. Complications related to pregnancy and childbirth are the main causes of women's mortality in

Mali [3]. WHO estimates that 25% of neonatal deaths worldwide could be prevented by birth spacing [1]. After several years of efforts to promote family planning, Mali's contraceptive prevalence remains low, at only 5.7% for modern methods [1]. According to DHS III, 38% of married women would like to attendbirths or stop having children, but do not use any contraceptive method [3]. During the period 1996-2001, the high infant mortality rate correlated with the contraceptive prevalence rate, i.e. FP use decreased in areas where infant mortality was increasing [3]. Apart from the desire to have more children, the main explanations for not using FP include: lack of information, concerns about health effects, and disapproval of FP. Since June 1972, Mali has opted for family planning (FP) with the creation of the Malian Association for the Promotion and Protection of the Family (AMPPF). But FP services were not effectively integrated into maternal and child health activities until 1978 with the advent of the primary health care strategy [1]. A descriptive analysis of abandonment of conception, based on Demographic and Health Survey data from six countries with high levels of contraceptive use, reveals that about one-third of couples stop using their method within 12 months and about half stop using their method within 24 months. IUD carriers are the least likely to stop using their method, with 82% to 89% of carriers persisting after one year and 65% to 80% continuing after two years. The levels of abandonment of other modern methods are similar to those of traditional methods, but the reasons for abandonment vary. For hormonal contraceptives and the IUD, health issues (including side effects) are the most common reason. An accidental pregnancy is the dominant reason for withdrawal and periodic abstinence. Women using the pill or IUD are more likely to continue using it if their family reaches the desired size. However, an analysis of pill data indicates that education and residency have little or no influence on dropout levels [4]. In Burundi since 1983, the authorities have become aware of the stakes of demographic pressure on the development of the country to concretize this awareness, a national coordination office of the family planning program (CPPF) is set up in 1987. The CPPF became the National Reproductive Health Program (PNSR) in 1997, the final objective of this policy was the control of the demographic gallop through planning (FP), yet contraceptive prevalence in Burundi remains low (2 5.3%, end 2012) [5]. In Mali, despite the actions undertaken, the level of fertility remains among the highest in the world, at 6.1 children per woman [3]. It should be noted, however, that the prevalence of family planning was and remains to a large extent little evaluated in Mali, as the only reference study the E.D.S. (6.4% at the national level in 2006 [3] and 9.9% in 2012-2013 [3]. This contraceptive prevalence in Mali seems low compared to the efforts made by the Ministry of Public Health, which continues to make enormous efforts to popularize the use of modern methods of contraception and this is explained by the fact that family planning is less used in our population for various reasons.

MATERIALS AND METHODS

This was a prospective, descriptive and cross-sectional study on the reasons forcontraceptive abanton at the Centre de Santé de ReEferencence de la C ommune V du district de Bamako. Our study ran from January 1, 2020 to December 31, 2020. It covered all clients received at the family planning unit. We conducted a comprehensive recruitment of all former users ofthe family planning unit who met our inclusion criteria. All former users ofthe family planning unit who received and agreed to participate in the study were included in this study. Not all former family planning service users who received and did not agree to participate in the study were included in this study. Data collection consisted of an interview with former family planning users on sociodemographic data and the reasons that led them to abandon contraception. These were open-ended questions with a transcription into French of the statements made by former family planning users interviewed generally in the Bambana language. Analysis and data entry were performed by SPSS version 20 software. Text input was done by Microsoft Word 2010. The following variables were studied: age, occupation, marital status, matrimonial regime, level of education, gynecological history, reasons for abandoning contraception. Ethically, the confidentiality and anonymity of each client were respected.

RESULTS

During the study period, we collected 1099 clients in family planning unit consultation, 200 of whom had mentioned their reason for dropping out, a frequency of 18.19%.

Table I: Frequency of discontinuation by contraceptive method

Methods	Number of clients	Number of abandonment cases	Percentage
Implant	920	120	13,04
IUD	80	20	25
Pills	30	10	33,33
Injectable	60	45	75
Mama	6	3	50
Necklace	3	2	66,66
Total	**1099**	**200**	**263,03**

Table II: Distribution of Clients by Age

Age	Actual	Percentage
≤ 19 years	20	10
19-34 years	140	70
≥ 35years	40	20
Total	**200**	**100**

NB: average age = 28.5, ± 8.4 years with extremes of 13 and 48 years.

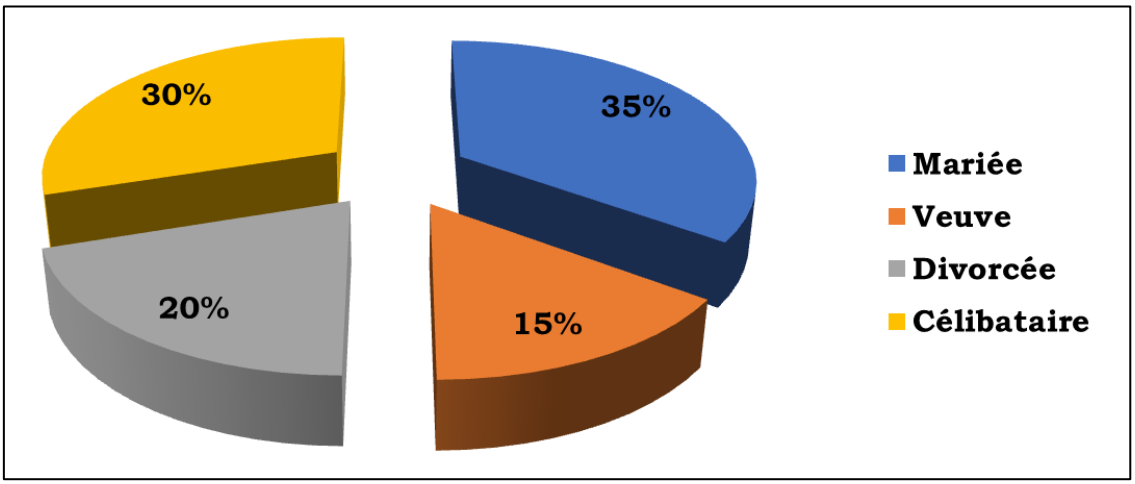

Figure 1: Distribution of Clients by Marital Status

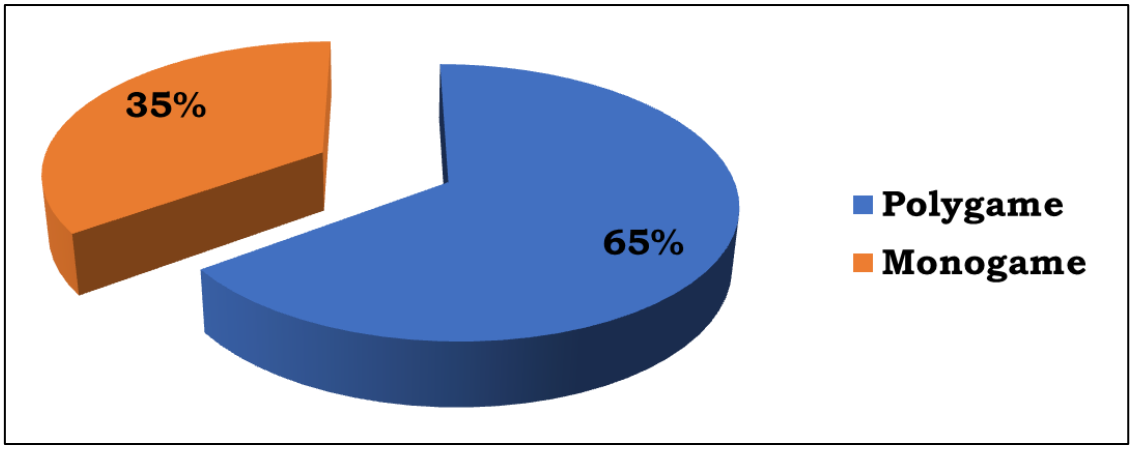

Figure 2: Distribution of Clients by Matrimonial Regime

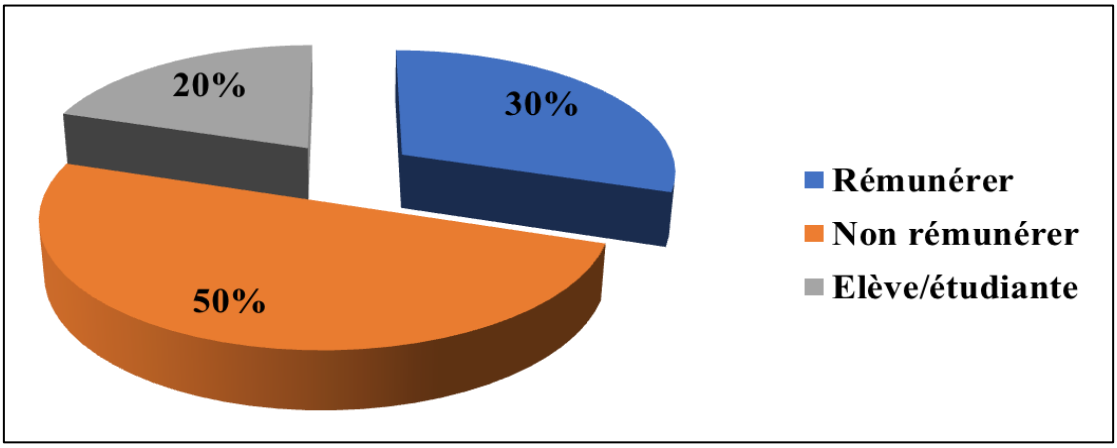

Figure 3: Distribution of Clients by Occupation

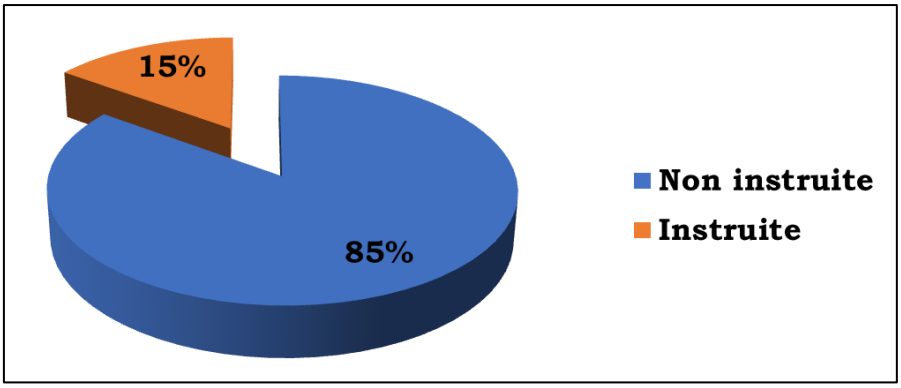

Figure 4: **Distribution of clients by level of education**

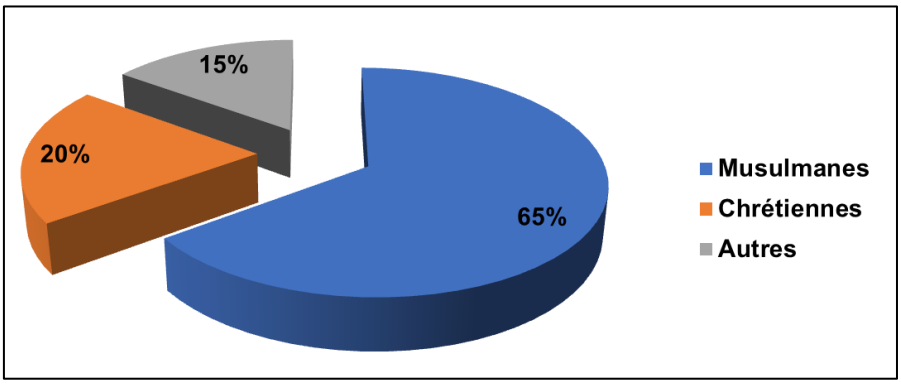

Figure 5: **Distribution of clients by religion**

Table III: Distribution of clients by source of information

Source of information	Actual	Percentage
Radio	30	15
Health structure	20	10
Health worker	20	10
Neighbour	30	15
Television	90	45
School	10	5
Total	**200**	**100**

Table IV: Distribution of clients by claimant qualification

Providers	Actual	Percentage
Doctor	30	15
Midwife	70	35
Internal	40	20
Nurse	60	30
Total	**200**	**100**

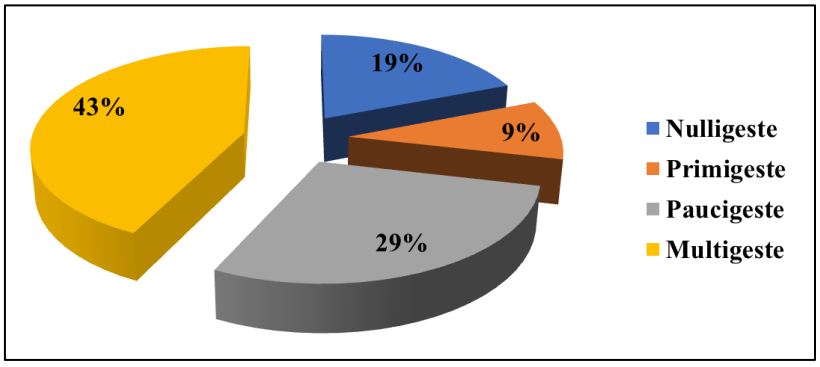

Figure 6: **Distribution of clients by pregnancy**

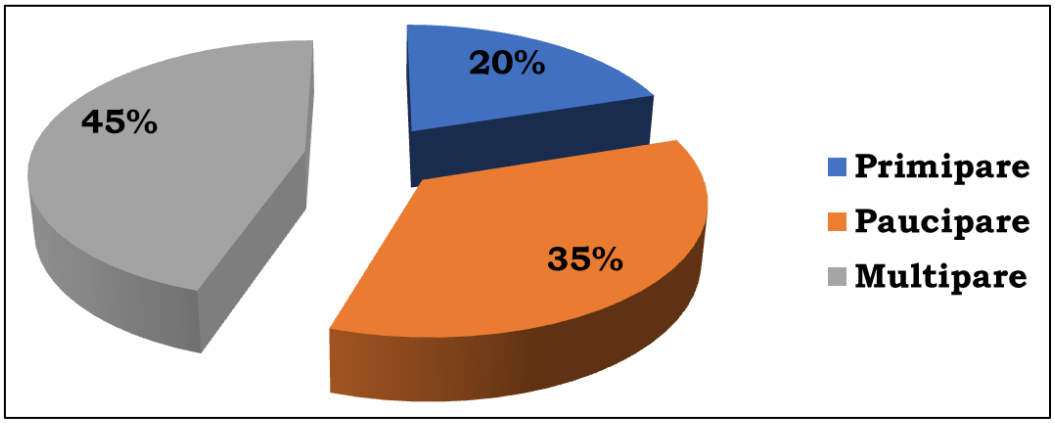

Figure 7: Distribution of Clients by Parity

Table V: Distribution of Clients by Intergenerational Interval

Interreproductive	Actual	Percentage
≥ 6 months	50	25
2 years	50	25
3 years	40	20
> 4 years	60	30
Total	**200**	**100**

Table VI: Distribution of clients by number of live children

Living children	Actual	Percentage
0	20	10
1-5	85	43
>5	95	47
Total	**200**	**100**

Table VII: Distribution of clients by number of abortions

Abortions	Actual	Percentage
0	80	40
1 – 3	20	10
> 3	100	50
Total	**200**	**100**

Table VIII : Distribution of Clients by Side Effects

Effects	Actual	Percentage
Amenorrhea	20	29
Metrorrhagia	10	14
Cramp abdominal pain	10	14
Nausea and vomiting	5	7
Menorrhagia	20	20
Sppoting	5	7
Total	**70**	**100**

Table IX: Distribution of clients by complications

Complications	Actual	Percentage
Difficulty returning to fertility	20	50
Anaemia	16	40
Vasculo-cerebral accident	1	3
Uterine perforation	3	7
Total	**40**	**100**

Table X: Distribution of clients by contraceptive rumors

Type of rumours	Actual	Percentage
Religious education	80	40
IUD gossip	70	35
Ideas brought by Westerners	10	5
Sterilization	40	20
Total	**200**	**100**

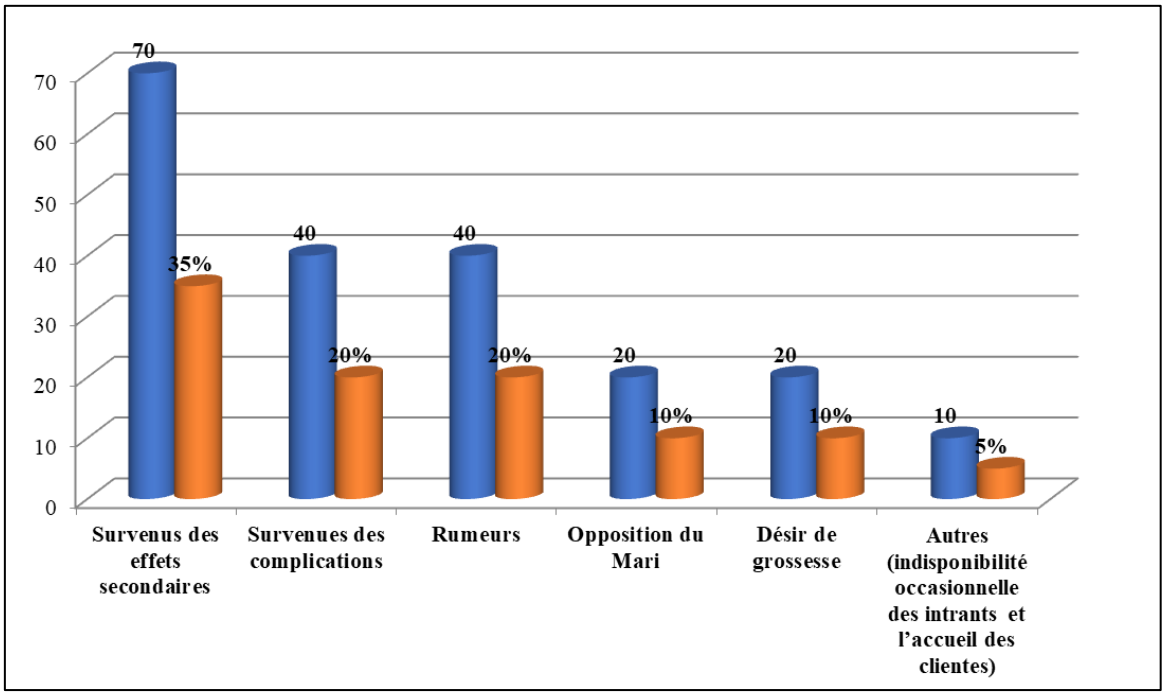

Figure 8: Distribution of Clients by Reason for Abandonment

Other reasons were put forward such as the shortage of stocks and the reception of customers with a proportion of 5%.

Table XI: Distribution of clients by side effects and type of contraception

Side effect	Jadelle	Pill	IUD	Deposit
Amenorrhea	Yes	Yes	No	Yes
Metrorrhagia	Yes	No	No	Yes
Cramp abdominal pain	No	No	Yes	No
Nausea and vomiting	No	Yes	No	No
Metrorrhagia	Yes	No	Yes	Yes
Sppoting	Yes	No	Yes	Yes

Table XII : Distribution of clients by side effects and type of contraception

Complications	Jadelle	Pill	IUD	Deposit
Difficulties in returning to fertility	Yes	Yes	No	Yes
Anaemia	Yes	No	No	Yes
Vasculo-cerebral accident	Yes	Yes	No	Yes
Uterine perforation	No	No	Yes	No

DISCUSSION

During the study period out of a total of 1099 clients seen in a family planning unit, 200 had mentioned their reasons for dropping out**,** a frequency of 18.19%. This frequency is very high compared to the enormous efforts made by the health authorities of commune V and its partners for the popularization of family planning. The NationalProgramme of Reproductive Health in Burundi found in one study a frequency of 25.3% in 2014 [5]. The 19-34 age group was the most represented with a frequency of 70%. The mean age was 28.4 years ± 8.4 years with extremes of 13 and 48 years. This is the period when the exposure to the risk of pregnancy is the highest and therefore the period par excellence of procreation. In our study, 70%

of the cases of cessation were due to the side effects of contraception. Thus most of these women say after having been confronted with side effects that were not taken care of promptly, and therefore pushed them to abandon contraception. The words of this young client go in this direction "faced with prolonged bleeding, after inserting the strand of match (jadelle), I was not satisfied when I went to the hospital to see my midwife. So I abandoned it permanently, so as not to die from the bleeding." To another client to say "after my last delivery my husband and I decided to space the births, but since I started with the pill, I no longer saw my period and I had a lot of discomfort, so I stopped and gave up contraception". Another 38-year-old SMA says "I have 7 children alive and after my last delivery, I had decided not to have any more children, so I started to do the 3-month injection (Depoprovera), which at some point started to make me bleed, which prevented me from praying, when I was consulted in the family planning unit, I was not well taken care of; I then stopped and decided not to do contraception anymore." A study conducted in 2008 in the same structure by SAO OB [8] on the evaluation of the quality of care in the family planning unit had reported that secondary amenorrhea was the most encountered side effect with a frequency of 30%. A study carried out by Dao N [6], at the Reference Health Center of Commune V of Bamako reported that the side effects reported were metrorrhagia (50%) and amenorrhea (30%). In our series 40% of dropouts were due to contraceptive complications. The most serious complications were the migration of the intrauterine device from the immediate postpartum period and the sequelae of vasculocerebral accidents. These are the complications that drive many women to ban family planning for life and make them anti-family planning activists. As testified by this client AK "I underwent emergency surgery following the migration of the IUD that I had placed after my last delivery, so I decided to give up contraception". Another BS student client says, "I am hemiplegic today because of hypertensive complications of the pill (Stediril). Should I continue to use poisons? . And that's my reason for giving up contraception." A study carried out in Morocco in 1996 [7] by the Division of Family Planning and the University of TULANE as part of the "Evaluation" project on the qualitative study on the intrauterine device found that the most formidable complication mentioned by the providers of the service surveyed was uterine perforation, i.e. 7% of cases. In our sample, 20% of abandonment cases were related to pressure from the husband. Thus MB 28 years old tells "After the complications of my last delivery, I used the condom if I am at my day of danger, and my husband was totally opposed to that, I then abandoned contraception for its respect and in the name of balance in the couple ". Another 32-year-old client said, "My husband objected to me planning because he believes the child is a gift from God and preventing his coming into the world goes against the Muslim religion. That's why I gave up contraception." In our study, 20% of contraceptive cessation cases were related to a desire for pregnancy. Married women were the most represented with 35% of cases of which 70% were on polygamous diets. Married women, especially those living in polygamous households, tended to compete on the number of living children; as evidenced by the words of this 30-year-old client "With a co-wife who has 05 living children and I only one; When I thought about that, I decided to stop contraception." Some single women bored for waiting too long to be married end up resigning themselves to having a child; as this young client says "Although I am single at 38, I gave up contraception so as not to die childless because of advancing age". A 1995 study by Muhammad Ali and John Clenand [4] on contraceptive discontinuation in six developing countries shows that the frequency of desire to have children during a period of 12 to 24 months increased the duration of contraception.

Table XIV: Frequency of desire for children over the period from 12 to 24 months

Country	Desire for a child	
	12 months	24 months
Morocco	9,8%	18,4
Tunisia	5,8%	12,3%
Egypt	5,3%	13,8%
Ecuador	5,9%	10,7%
Indonesia	7,5%	14,4%
Thailand	14,1%	23,0%

In our series 40% of our clients have been influenced by false rumors without any foundation ; as evidenced by the words of this client "It seems that the << toubabs >> (Western) invented contraception just to prevent us from being so numerous because contraception, prevents us from getting pregnant after having the used. So after hearing this rumor I gave up contraception, because they say a wise man is worth two." Another client in her expression tells us "The insertion of the IUD gave me cramps and incessant abdominal pain. When I explained this to a friend, she told me that maybe the IUD has gone up to the abdomen that's what gives you so much discomfort; From then on I quickly went to the hospital to get rid of it and give up contraception for good" The Division of Family Planning and the University of TULANE, during a study in 1996 [7], shows that the rumors most evoked were "it embarrasses the husband"; "can sting the husband during sexual intercourse"; "can migrate inside the body, to the heart, back, ribs." It can be found in the child at birth, at the level of the head, the forehead. "

CONCLUSION

Inadequate management of contraceptive side effects and complications; desire for pregnancy; husband's reluctance and rumours were the determining factors for contraceptive abandonment during our study; and four main aspects merit the attention of

reproductive health actors in order to make improvements. These include communication around side effects, management of side effects, competence of providers and strengthening dialogues related to family planning within couples.

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