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Accessibility and barriers to contraceptive use among married couple's in Kirehe district-Rwanda

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ABSTRACT

The use of contraceptive method use remains uncommon among married couples globally. Non-use in young couples contributes to higher fertility rates. Contraceptive methods serve several purposes, including, the reduction of maternal and infant morbidity and mortality rates, sustainable population growth rate, improved economy security for both family and community and treatment of infertility among others. Despite these huge benefits, many factors stand to impede on their use. This cross-sectional community-based study examined the accessibility and barriers to contraceptive use among married couples in Kirehe district, Rwanda. The researcher put into consideration ethical issues related to the research. Research permit and letter from the Mount Kenya University has been used to obtain permission to carry out the research study in Kirehe District according to the

required rules and regulations of the Kirehe District administrative authorities. This research is significant because it will update Kirehe communities on the type of contraceptive method found in Rwanda. It will also serve as a reference point and guideline for future researchers on the subject matter. The study will show the various challenges and coping strategies for some married couples on how to deal with the issue. Both cluster and systematic sampling were used for selecting the 75 married couples and 25 key informants to interview. The study adopted both quantitative and qualitative methods and the data were analyzed using SPSS. Among 75 respondents, 62.7% were females, 46.7% were aged more than 30 years old, 60.7% of husbands had secondary school, 61.7% of spouses had secondary school, 46.4% of husbands were self-employed, 53.2% of spouses were self-employed, and 41.3% were Catholics. The research findings revealed that married couples in the study area were mainly using different types of contraceptive methods such as pills (30.7%), implants (22.7%), DIU (18.7%), and lactation amenorrhea method (10.7%). The number of births (AOR=3.8; 95%CI: [1.41-8.249]; p=0.021) and AOR=8.1; 95%CI: [1.32-74.6]; p=0.044), number of children (AOR=5.7; 95%CI: [1.38-23.44]; p=0.016), charges required to pay (AOR=4.8; 95%CI: [1.47-21.67]; p=0.011), getting information on contraceptive methods (AOR=8.8; 95%CI: [1.82-52.9]; p=0.009), and the influence of Rwandan society (AOR=3.7; 95%CI: [1.04-42.37]; p=0.0298) have been found to be associated with the use of contraceptive methods. From the qualitative part, different challenges have been disclosed to handicap the adherence to the contraceptive methods such as young age, the will of giving too many births, inaccessibility to the contraceptive methods, rumors, and misinformation towards contraceptive methods. The health education, reinforcement of the right of mothers known as “*Akagoroba k’ababyeyi*”, attending antenatal care services and improving the accessibility to the use of contraceptive among these married couples have been suggested as strategies of increasing the adherence to the contraceptive methods use. The study results suggest that simply ensuring that couples are aware of contraceptive methods and their availability is not enough to generate extensive changes in behavior and/or perceptions. It is critical to address these persistent challenges with married men and women alike to promote mutual understanding, awareness, and decision-making in regard to the use of contraceptive methods.

Introduction

Globally over 30 percent of maternal and child deaths are a result of abortion (Nisingizwe, et al., 2014), (Farmer, et al., 2015). Based on the 2017 World Health Organization (WHO) report, stating that more than 287,000 maternal deaths always happen in sub-Saharan Africa (56%) and then Southern Asia (29%) respectively. These represent for the global burden of maternal deaths. Despite this decline, developing countries continued to account for 99% of the maternal deaths. The majority of maternal and newborn deaths can be avoided with established interventions to ensure that each and every being pregnant is wanted, the usage of FP and every birth is secure (Hinkosa, 2018).

Many sub-Saharan Africa countries have high rate of unmet need for family planning and low rate of contraceptive use (Ezeh, Bongaarts, & Mberu, 2012). Contraceptive use and family planning are widely acknowledged as an essential intervention towards accomplishing Sustainable Development Goals (SDGs) four (4) and five (5) as it has proven to reduce maternal and child mortality (Wulifan, et al., 2018). Contraceptive use can prevent unwanted pregnancies and unsafe abortions and some family planning methods such as condom utilization can protect people from Sexually Transmitted Infections (STIs) together with HIV/AIDS (World Health Organization, 2012). Despite the extensive benefits of family planning services, the uptake of the service nonetheless stays low in Sub-Saharan Africa (Silumbwe, et al., 2018).

Rwanda has made great progress, through strong leadership, good governance and positive implementation, Rwanda has built its health system from 1994 and hence has achieved extensive improvement in many health indicators, such as family planning. The level of contraceptive prevalence rate in Rwanda has been rising amongst women of all ages, almost tripling from 13% to 36% between 2000 to 2008 (Bucagu, et al., 2012). that is why Rwanda made significant strides in improving the health of its people, including growing access to and use of family planning. Family planning use increased from 17% to 53% in just ten years, from 2005 to 2015

A study conducted by the Ministry of Health, the National University of Rwanda's school of Public Health and the U.S based Guttmacher Institute, indicated that the National abortion rate is 25 abortions per one thousand women of reproductive age (15-49) (Nisingizwe, et al., 2014), (Farmer, et al., 2015). The study additionally confirmed that traditional healers besides expert information carry out most abortions. One of the reasons given by women who sought traditional healers for abortion was that abortion is illegal in Rwanda regulation.

Contraceptive use and family planning (FP) in standard are integral rights of each human being, Family planning is an approach that in many instances consists of a dialogue between a woman, a man, and knowledgeable health caregiver focusing on family planning and the willing of the couple to both restrict or extent their family (Swamy, 2017). This is the key technique to promote mother and infant wellbeing through birth spacing and ward off pregnancy at high risk of maternal ages and parities. A woman's potentiality to space her pregnancies has a direct effect on her wellbeing and the outcome of her pregnancy. In other words, decreasing unwanted pregnancies may reduce childbirth associated injury, sickness, life lost and abortion also family planning reduce death, improve health, and facilitate financial improvement in resource limited settings (Ademuyiwa, 2016).

in Kirehe district, the number of women who have adopted family planning in Kirehe district is still low. According to an evaluation report on the district performance contracts presented last week, only 13.6 percent of the 70,408 married couples in the district have adopted family planning methods. The report also showed that only 39 percent of pregnant women in the district give birth in health centers. Only 3 percent has been achieved in the fight against malaria infection.

Research methodology

This cross-sectional community-based study with mixed design was used to examine the accessibility and barriers to contraceptive use among married couples in Kirehe district, Rwanda. A total of 100 respondents were selected through systematic and cluster sampling to meet. This study used both quantitative and qualitative methods to assess the accessibility and barriers among married couples in Kirehe district. A structured questionnaire was used for quantitative data collection and an interview guide was used for qualitative data collection.

Study population and procedure of the study

To meet the purpose of this research, for quantitative data, 92 married couples were targeted and for qualitative data, there were 25 key informants selected through the district. For quantitative data collection, a structured questionnaire was used to collect the data. Questions were planned and created in advance, which means that all respondents were asked the same questions in the same order. For qualitative data, interviews were conducted to the KIs by using the interview guide.

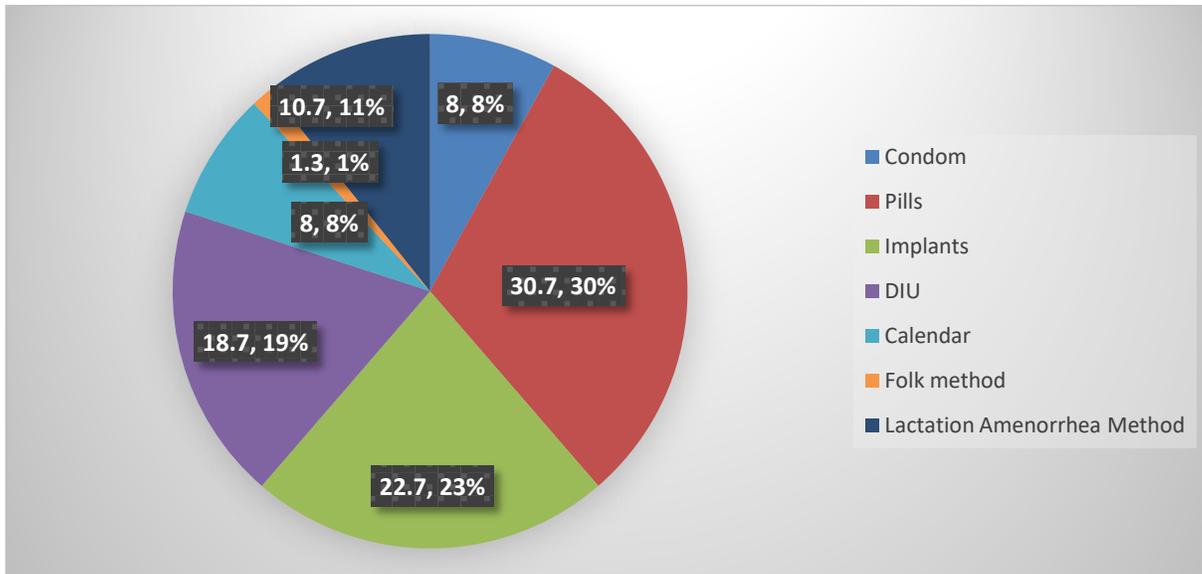
Data were collected from Jan to Sept 2021. The total days of data collection were 20 days. The researcher worked closely with the Community health workers (CHWs) in data collection as they are part of the community and familiar with the population in their communities. A small amount for motivation fee was provided to the CHWs to facilitate their transport on the field. Note that the structured questionnaire was translated in Kinyarwanda and pre-tested to ensure that it maintained its original meaning.

Data Analysis

Data were collected and cleaned to ensure its completeness and accuracy by using SPSS version 21 for quantitative data. The analyzed data were presented using frequencies, percentages and cross-tabulated. To verify/prove the relationship between the dependent and the independent variables, the Pearson Chi-square test was performed at 95% confidence interval. The logistic regression model (multivariate analysis) has been used to calculate odds ratio and the corresponding 95% confidence interval. A two-tailed p-value of less than or equal to 0.05 has been used in order to state the statistical significance or not. Qualitative data was classified and coded into themes and concepts. Key information and quotations were synthesized and tabulated in order to know the information saturation.

Results

4.2.1 Types of contraceptive methods used by married couples in Kirehe district



Source: Primary data (2021)

Findings from this study specified that married couples in the study area were mainly using pills (30.7%), implants (22.7%), DIU (18.7%), and lactation amenorrhea method (10.7%). It has also revealed that 50.7% of respondents were using between 30 minutes to one hour to reach the health facility, by walking on feet (66.7%), 57.3% revealed they are waiting more than one hour to be served at health facility and there are requested to pay for services related to contraceptive methods. The majority (84%) revealed they had access to information on contraceptive methods use and the main sources of information found to be the radio/TV (40%) and CHWs (28%).

Table 4.5. factors of contraceptive methods and type of contraceptive methods used

Variables	Items	Contraceptive method used		Pearson Chi-square (X ²)	P-value
		Modern	Traditional		
Distance from home to health facility	< 30 min	16(88.9)	2(11.1)	2.747	0.432
	30 min to 1 hour	29(76.3)	9(23.7)		
	1 hour to 2 hours	12(85.7)	2(14.3)		

	Above 2 hours	3(60.0)	2(40.0)		
Waiting time for service at health facility	15 min to 30 min	20(87.0)	3(13.0)	1.977	0.372
	30 min to 1 hour	8(88.9)	1(11.1)		
	Above 1 hour	32(74.4)	11(25.6)		
Mode of transport to the health facility	Private transport	3(100.0)	0(0.0)	1.375	0.711
	Public transport	16(80.0)	4(20.0)		
	Feet	39(78.0)	11(22.0)		
	Bicycle	2(100.0)	0(0.0)		
Number of children in family	1-3 children	38(92.7)	3(7.3)	11.329	0.003
	4-6 children	20(69.0)	9(31.0)		
	Over 6 children	2(40.0)	3(60.0)		
Perception of contraceptive method use	Good	27(90.0)	3(10.0)	3.125	0.077
	Bad	33(73.3)	12(26.7)		
Charges requested for service related to CM	Yes	39(90.7)	4(9.3)	7.208	0.007
	No	21(65.6)	11(34.4)		
Experience in CM use	Good	17(89.5)	2(10.5)	1.427	0.232
	Bad	43(76.8)	13(23.2)		
Women experienced side effects due to FP (n=47)	Yes	28(90.3)	3(9.7)	0.695	0.706
	No	11(84.6)	2(15.4)		
	Sometimes	3(100.0)	0(0.0)		
Presence at the HF for FP	Both husband & spouse	26(89.7)	3(10.3)	2.755	0.097
	Spouse only	34(73.9)	12(26.1)		
Family talk on contraceptive method's choice	Yes	12(80.0)	3(20.0)	2.845	0.241
	No	19(70.4)	8(29.6)		
	Sometimes	29(87.9)	4(12.1)		
Belief and trust of CM use	Good	24(92.3)	2(7.7)	3.768	0.052
	Bad	36(73.5)	13(26.5)		
Contraceptive method use	Yes	18(85.7)	3(14.3)	3.019	0.221

willingly	No	6(60.0)	4(40.0)		
	Sometimes	36(81.8)	8(18.2)		
Access to information on	Yes	53(84.1)	10(15.9)	4.191	0.041
contraceptive method use	No	7(58.3)	5(41.7)		
Sources of information on	Radio-TV	27(90.0)	3(10.0)	9.241	0.026
contraceptive method use	CHW education	18(85.7)	3(14.3)		
	All of the above	9(75.0)	3(25.0)		
	None	6(50.0)	6(50.0)		
Commitment to the ongoing	Yes	42(91.3)	4(8.7)	9.600	0.008
CM use	No	18(32.1)	11(37.9)		

Source: Primary data (2021)

Several studies have reported on the role of men's involvement in the uptake of family planning services in Nigeria (Blackstone & Iwelunmor, 2013), Nigeria (OlaOlorun & Hindin, 2014) and Kenya (Lasee & Becker, 2017). Findings of this current study revealed a significant relationship between the type of contraceptive method used and the subscription to the health insurance ($p < 0.001$), number of children in family ($p = 0.003$), charges requested in family planning ($p = 0.007$), access to information on contraceptive methods ($p = 0.041$), source of information ($p = 0.026$), commitment to the contraceptive methods ($p = 0.008$), family planning conception in Rwandan society ($p = 0.036$), and the influence of Rwandan society ($p = 0.030$). It was revealed that 40% of the respondents agreed that there were not supported by their husbands in contraceptive use. This was not far from the results from a study conducted in Nigeria where among the 20.5% that did not apply the family planning services, was a result of husband's disapproval (Julius, et al., 2020).

Table 4.1 Challenges faced, and type of contraceptive methods used

Variables	Items	Contraceptive method used		Pearson Chi-square (X^2)	P-value
		Modern	Traditional		
Spouse faced any threat due to CM use	Yes	8(72.7)	3(27.3)	5.114	0.078
	No	42(87.5)	6(12.5)		
	Sometimes	10(62.5)	6(37.5)		
Husband's support for their spouses in CM use	Yes	17(85.0)	3(15.0)	0.521	0.771
	No	23(76.7)	7(23.3)		
	Sometimes	20(80.0)	5(20.0)		
FP conception in Rwandan society	Yes	42(61.1)	14(38.9)	6.652	0.036
	No	18(94.7)	1(5.3)		
Any influence of Rwandan society	Yes	44(95.0)	6(5.0)	7.021	0.030
	No	16(64.0)	9(36.0)		
Any influence of churches on CM use	Yes	9(81.8)	2(18.2)	0.058	0.971
	No	34(79.1)	9(20.9)		
	Sometimes	17(81.0)	4(19.0)		
Receiving support from CHWs of family planning	Yes	27(87.1)	4(12.9)	1.989	0.370
	No	18(72.0)	7(28.0)		
	Sometimes	15(78.9)	4(21.1)		
Authority's sensitization of families on FP	Yes	10(90.9)	1(9.1)	1.383	0.501
	No	35(76.1)	11(23.9)		
	Sometimes	15(83.3)	3(16.7)		
Healthcare providers' mobilization on CM use	Yes	12(85.7)	2(14.3)	1.092	0.579
	No	31(75.6)	10(24.4)		
	Sometimes	17(85.0)	3(15.0)		
Family neighbor as role	Yes	36(85.7)	6(14.3)	1.948	0.163

model in CM use	No	24(72.7)	9(27.3)
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Source: Primary data (2021)

Research findings from a bivariate analysis revealed that the conception of family planning ($p=0.036$), and influence of Rwandan society ($p=0.030$) were found to be statistically significantly associated with the type of contraceptive methods used (Table 4.6). A study conducted in Nigeria by Julius *et al.* (2020) indicated that about 72% of the participants cited the involvement of husband and wife in the decision making on reproductive health and family welfare helps in the adoption of family planning services. This was different with what found in this study during the interviews where it has revealed by key informants that married couples were less involved in family planning compared to what was expected in the study area. Generally, women's perception of their spouse approval goes a long way in the uptake of the services. However, a report on women who do not use family planning services showed about 73.6% who do out of their own personal opposition and without male partner disapproval (Osaro & Mezie-Okoya, 2017).

Table 4.2 Predictors of the choice of the type of contraceptive methods used

Variables	Items	Crude OR (95%CI)	P- value	Adjusted OR (95%CI)	P-value
Health insurance	None	Ref.			
	Mutuelle de santé	0.01(0.002-0.12)	0.070	0.008(0.001-0.09)	0.064
	MMI	0.09(0.006-1.49)	0.094	0.07(0.003-0.09)	0.097
	RSSB	0.05(0.006-0.50)	0.081	0.04(0.004-0.70)	0.071
	Radiant	0.19(0.01-2.06)	0.172	0.14(0.07-2.14)	0.167
	UAP	0.28(0.01-6.91)	0.441	0.21(0.007-4.26)	0.557
	SANLAM	-	0.999	-	-
Number of births in family	1-3 births	Ref.			
	4-6 births	4.6(1.26-16.93)	0.011	3.8(1.41-8.249)	0.021
	≥7 births	9.7(1.06-89.20)	0.035	8.1(1.32-74.6)	0.044
Number of children in	1-3 children	Ref.			

family	4-6 children	2.2(0.14-33.93)	0.009	5.7(1.38-23.44)	0.016
	Over 6 children	1.3(0.104-17.09)	0.358	6.0(0.221-16.25)	0.287
Charges requested for service related to CM	Yes	Ref.			
	No	5.1(1.44-18.02)	0.014	4.8(1.47-21.67)	0.011
Access to information on CM use	Yes	Ref.			
	No	3.7(0.99-14.34)	0.054	2.5(0.357-17.5)	0.050
Source of information on CM use	Radio-TV	9.0(1.73-46.59)	0.006	8.8(1.82-52.9)	0.009
	CHW education	1.5(0.27-8.27)	0.474	0.6(0.107-3.474)	0.642
	All of the above	3.0(0.51-17.59)	0.239	2.4(0.42-16.84)	0.224
	None	Ref.			
Commitment to the ongoing CM use	Yes	Ref.			
	No	2.8(0.56-14.06)		6.1(1.71-21.81)	0.005
FP conception in Rwandan society	Yes	Ref.			
	No	3.5(0.28-43.44)	0.322	3.1(0.17-47.21)	0.274
Influence of Rwandan society to CM use	Yes	Ref.			
	No	3.8(0.40-35.28)	0.032	3.7(1.04-42.37)	0.0298

Source: Primary data (2021)

the researcher concluded that families with 4-6 births and more than 7 births were more likely (AOR=3.8; 95%CI: [1.41-8.249]; p=0.021) and AOR=8.1; 95%CI: [1.32-74.6]; p=0.044, respectively) to use contraceptive methods than those with 1-3 births, 5.7 times (AOR=5.7; 95%CI: [1.38-23.44]; p=0.016) among respondents with 4-6 children than those with 1-3 children, 4.8 times (AOR=4.8; 95%CI: [1.47-21.67]; p=0.011) among respondents who did not pay any charge when requesting service related to contraceptive methods than those paid those services, 8.8 times (AOR=8.8; 95%CI: [1.82-52.9]; p=0.009) among respondents getting information on contraceptive methods through radio and television than those who did not accede to those information, 3.7 times (AOR=3.7; 95%CI: [1.04-42.37]; p=0.0298) among respondents not influenced by Rwandan society than those influenced by Rwandan society.

This finding showed a consistency with what found in a study conducted in Nigeria where women who communicated and had their spouse approval were 9.6 times likely to utilize family planning services (Lasee & Becker, 2017). The implication is that, notwithstanding the important role of husband plays in the uptake of family planning services, cumulative of several other factors as

indicated by this study and others all serve to influence about 214 million women in the developing countries who are not using modern contraceptive method (WHO, 2018).

Challenges experienced by married couples in having access to contraceptive methods and related coping strategies

Findings from the qualitative part of this study, different challenges have been discovered to handicap the adherence to the contraceptive methods such as young age, the will of giving births, inaccessibility the contraceptive methods, rumors, and misinformation towards contraceptive methods. These findings were somehow similar to what found in rural India which demonstrated that sociocultural concerns related to expectations of pregnancy early in marriage (pro-natal norms), importance of having boys (son preference), and lesser control for women relative to men or even in-laws in reproductive decision making (low female reproductive control) remain key barriers to non-use of spacing contraception.

Such findings appeared to be similar to those seen in prior research (Liberhan, 2013), (Santhya, 2014), (Athavale & Athavale, 2013), (Blanc, 2011) and (Chacko, 2017) suggested that changes in normative beliefs related to gender, marriage and family planning have altered little over the past 20 years.

In this study as in others undertaken in rural areas, women pointed out that their husband's resistance to contraceptive methods was a major barrier to use, even in the rare cases of joint decision-making (Bogale, et al., 2017). Although men play the role of decision-maker, they are often detached from and lack interest in reproductive health issues, particularly in rural patriarchal communities like Ugandan community (Kabagenyi, et al., 2014).

A study conducted in rural Ghana indicated that despite the fact that a majority of women considered family planning acceptable, an even higher percentage of women expressed that they would require the permission of their partners before they actually adopted a modern contraceptive method. Consistent with the results of this study, this finding suggests that a woman's personal conviction is insufficient to ensure actual uptake of modern contraceptive methods. The Ghanaian study also disclosed, however, that men and women had similar levels of acceptance of family planning, which could point to inadequate spousal communication leading to an inaccurate perception of male partners' opinions in some instances (Eliason, et al., 2013).

Furthermore, qualitative researches undertaken in other sub-Saharan African countries also supported the suggestion that husband's involvement in family planning can increase uptake and continuation of contraceptive use by improving spousal communication (Kabagenyi, et al., 2014), and (Vouking & Tadenfok, 2014).

Discussions

This study mainly examined the accessibility and barriers to contraceptive methods use among married couples in Kirehe district in Rwanda. It has shown that the pills were widely used (30.7%) followed by implants (22.7%) and DIU (18.7%) while the

folk method was less practiced (1.3%). These findings were totally different with what found in Nigeria by Julius *et al.* (2020) where they found that the use of oral contraceptive was widely adopted compared to the cervical cap which was less used. This was explained by the fact that, in Nigeria, the type of method found suitable for reasons mentioned were including less cost, access, ease in the use, less side-effects and so on affects the uptake of the services. Results indicate that majority of respondents (66.0%) reported that women were experiencing side effects due to family planning, and 57.3% revealed they paid when requesting for services related to contraceptive methods. This was somehow similar with what found by Julius *et al.* (2020) where about 25.8% had no access to contraceptives and about 49.0% reported non-use due to side-effects. This implies that, stock out of the preferred choice of contraceptive and perceived side-effects may be responsible for those 49.0% with reported non-usage.

Findings of this current study revealed a significant relationship between the type of contraceptive method used and the subscription to the health insurance ($p < 0.001$), number of children in family ($p = 0.003$), charges requested in family planning ($p = 0.007$), access to information on contraceptive methods ($p = 0.041$), source of information ($p = 0.026$), commitment to the contraceptive methods ($p = 0.008$), family planning conception in Rwandan society ($p = 0.036$), and the influence of Rwandan society ($p = 0.030$). It was revealed that 40% of the respondents agreed that there were not supported by their husbands in contraceptive use. This was not far from the results from a study conducted in Nigeria where among the 20.5% that did not apply the family planning services, was a result of husband's disapproval (Julius, *et al.*, 2020).

Even though the evidences from other studies showed that women who have had more than four pregnancies were at an increased risk of maternal mortality (WHO, 2018), the study findings revealed that couples with 4-6 births and more than 7 births were more likely (AOR=3.8; 95%CI: [1.41-8.249]; $p = 0.021$) and AOR=8.1; 95%CI: [1.32-74.6]; $p = 0.044$, respectively to use contraceptive methods than those with 1-3 births. The role in which the socio-cultural factors such as the preference for more children, especially male children by families and communities for several reasons but importantly for the purpose of heritage affects the adherence to the contraceptive methods use among married couples.

Furthermore, the low contraceptive adherence in the study area could have been influenced by the accessibility to the information related to the use of contraceptive methods (AOR=8.8; 95%CI: [1.82-52.9]; $p = 0.009$). This was not the case in north central Nigeria revealed that the low contraceptive prevalence was influenced by the level of inaccessibility to preferred methods as indicated by about 25.8% (Julius, *et al.*, 2020).

Also, it was reported that, the odds of using contraceptive methods were 8.8 times (AOR=8.8; 95%CI: [1.82-52.9]; $p = 0.009$) among respondents getting information on contraceptive methods through radio and television than those who did not accede to that information. This finding showed a consistency with what found in a study conducted in Nigeria where women who

communicated and had their spouse approval were 9.6 times likely to utilize family planning services (Lasee & Becker, 2017). The implication is that, notwithstanding the important role of husband plays in the uptake of family planning services, cumulative of several other factors as indicated by this study and others all serve to influence about 214 million women in the developing countries who are not using modern contraceptive method (WHO, 2018).

Findings from the qualitative part of this study, different challenges have been discovered to handicap the adherence to the contraceptive methods such as young age, the will of giving births, inaccessibility the contraceptive methods, rumors, and misinformation towards contraceptive methods. These findings were somehow similar to what found in rural India which demonstrated that sociocultural concerns related to expectations of pregnancy early in marriage (pro-natal norms), importance of having boys (son preference), and lesser control for women relative to men or even in-laws in reproductive decision making (low female reproductive control) remain key barriers to non-use of spacing contraception. Such findings appeared to be similar to those seen in prior research (Liberhan, 2013), (Santhya, 2014), (Athavale & Athavale, 2013), (Blanc, 2011) and (Chacko, 2017) suggested that changes in normative beliefs related to gender, marriage and family planning have altered little over the past 20 years.

In this study women pointed out that their husband's resistance to contraceptive methods was a major barrier to use, even in the rare cases of joint decision-making (Bogale, et al., 2017). Although men play the role of decision-maker, they are often detached from and lack interest in reproductive health issues, particularly in rural patriarchal communities like Ugandan community (Kabagenyi, et al., 2014).

Conclusion

This study found that different types of contraceptive methods were accessible and used even if the rate of adherence to these contraceptive methods are still low. The study results suggest that simply ensuring that couples are aware of contraceptive methods and their availability is not enough to generate extensive changes in behavior and/or perceptions. It is critical to address these persistent challenges with rural men and women alike to promote mutual understanding, awareness, and decision-making in regard to the use of contraceptive methods.

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