

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

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ABSTRACT: Many unwanted pregnancies and its associated complications have resulted from refusal of some women of reproductive age to the use of contraceptives in general particularly the hormonal contraceptive in our environment. The fear of side effects, religious belief, ignorance and other myths surrounding the use of contraceptives had contributed to this. The main objective of the study was to find out if the reported side effects of hormonal contraceptives by women of reproductive age in Enugu, South Eastern Nigeria, are truth or myth. It was a combination of prospective and retrospective study with interviewer administered questionnaire to assess socio-demographic data, reasons why some women were not using hormonal contraceptives, side effects and benefits of hormonal contraceptives. From the 410 respondents, the study showed that 232 respondents (56.6%, $X^2=7.686$) of respondents used hormonal contraceptive which was significant ($p<0.05$). 178 respondents (43.4%) respondents did not use hormonal contraception. 76.0% of the hormonal contraceptives users had side effects while 24.0% did not. Irregular menses (44.4%) was the commonest side effect. 130 respondents (73.0%) gave reasons such as religious belief, ignorance, fear of side effects etc as preventing factors to the use of contraceptives. The study showed that 69.8% of users were not discouraged by side effects and 81.1% agreed to recommend it to their friends and family relatives because of its numerous benefits. While it was true from the study that hormonal contraceptives was associated with some side effects of which some disappeared without intervention within 3-5 months of use (35.1%), and others were taken care of through medical interventions, some myths (religious belief, ignorance, husband approval, etc) were also limitations against hormonal contraceptives use.

KEYWORDS: Pharmacodynamic, Myth, Health Personnel, Hormonal Contraceptives, Chemotherapy

INTRODUCTION

Family planning has proven to be an effective intervention for enhancement of maternal, newborn and child health. Despite several benefits from family planning, experience or concerns related to side effect by women potentiate a major barrier to the sustained use of contraceptives for family planning. This is often seen with hormonal contraceptives.

Side effects are unwanted but often unavoidable pharmacodynamic effects that occur at therapeutic doses while toxic effects are the result of excessive pharmacological action of drug due to overdose or prolonged use which leads to cell damage. Adverse drug reaction is any noxious and unintended effect that occurs at therapeutic doses in human for prophylaxis, diagnosis, or treatment of diseases, or modification of physiological function (Itodo et al, 2022). Hormonal contraceptives act on the endocrine system. Majority are composed of steroid hormones although selective estrogen receptor modulators such as ormeloxifene, is marketed as a contraceptive. It is believed that combined hormonal contraceptives (COC) work primarily by preventing ovulation and thickening cervical mucus (Cooper et al, 2022.). Progestogen-only contraceptives can also prevent ovulation and thickening of cervical mucus. Progestogen-only contraceptives rely more on thickening of cervical mucus. Ormeloxifene is a non-steroidal oral contraceptive taken once a week. In some parts of the body, its action is estrogenic (bones), in other parts of the body its action is anti-estrogenic (uterus, breasts). It causes an asynchrony in the menstrual cycle between ovulation and the development of uterine lining, although its exact mode of action is not well defined. Modern methods of family planning have been widely promoted as a mechanism to improve health, prevent maternal and child death and stabilize population growth, (Zhn, 2005). Many countries in sub-Saharan Africa are lagging behind with the adoption of modern contraceptive, (Cleland *et al*, 2006). The postpartum period is an important time to reach out to women and their families with key information regarding family planning. This is usually from delivery to six weeks, extending to one year after birth in the extended postpartum period, [World Health Organization (WHO), 2013]. The target information are counseling on healthy timing and spacing of pregnancy; return to fertility and risks associated with pregnancy after child birth, appropriate contraceptive options for individuals; the lactational amenorrhea method and timely transition to another modern method, (Gaffield *et al*, 2014). Sex education is also an important means of teaching adolescents

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

about contraception. There are over four-fifths of unmarried young people (15-24 years) in Nigeria that engages in one or more risky sexual behavior, (Adedini *et al.*, 2021). The poor usage of contraceptives especially in the third world countries necessitated the London 2012 family planning summit which launched a global movement to give additional 120 million women in the world's poorest countries access to life saving family planning information, services and supplies by 2020. This access will enable these women and girls to choose whether, when and how many children to have. The summit was an opportunity to generate global commitments to increase access to family planning and to speeding up the achievement of Sustainable Development Goal 3, (Family Planning Summit London, 2012). Another summit on family planning was held in London in 2017 to review the 2012 summit and it found out that 300 million women in developing countries adopted the use of modern methods of contraception, (Family Planning Summit London, 2017). The use of modern contraception has risen globally, slightly from 57.4% in 2015. Regionally, the proportion of women aged 15 – 49 years that reported the use of a modern contraceptive method had risen minimally between 2008 and 2015. In Asia it climbed slightly from 60.9% to 61.8%, in Latin America and the Caribbean it has remained stable at 66.7%, [United Nations Department of Economic and Social Affairs, (UNDESA, 2015 & 2018)]. In Africa it went from 23.6% to 28.5%, while in the South East Nigeria, Chigbu *et al.* (2010) showed high prevalence of hormonal contraceptives especially the injectables in Aba.

Globally, among women of reproductive age (15-49 years) that are married or in union, the proportion that their need for family planning were satisfied by modern method increased from 75% in 2000 to 77% in 2018. There has been significant progress especially in the least developed countries, where this proportion increased from 39% in 2000 to 59% in 2018. Nevertheless, in 2018 there remain 45 countries, with 27 in sub-Saharan Africa, where less than half of the existing need for family planning is satisfied with modern methods, (UNDESA, 2015 & 2018). There is considerable evidence based on previous studies that the fear and evidence of side effects of contraceptives has generally contributed to the low percentage use of modern contraception in sub-Saharan Africa just like fear of adverse reaction to HAART must have prevented some HIV/AIDS from ART (Chebet *et al.*, 2015; Itodo *et al.*, 2022).

This study is aimed at finding out if the reported side effects of hormonal contraceptives by women of reproductive age in some selected health facilities in Enugu state are true or myth.

METHODOLOGY

Study Design

It was a combination of prospective and retrospective study conducted in four months among women attending the family planning and antenatal clinics of Enugu State University Teaching Hospital, Parklane, Enugu, Nwani General Hospital and Udi General Hospital, Enugu. Data from the patient hospital folders and structured questionnaires were used to retrieve information from the patients.

Study Area

Enugu State University of Science and Technology Teaching Hospital, (ESUTH), Parklane, Enugu is a tertiary health institution located in Enugu State, Nigeria. The hospital boasts of a very good number of patients and not less than 150 bed spaces. It provides family planning and antenatal clinic services to not less than 4,000 women within the study period. Also, General Hospitals in Uwani and Udi are secondary health institutions located in Enugu State. Each offered both antenatal and family planning services to not less than 1000 women as at the time of the study and boast of 30-40 bed spaces.

Sample Size

The sample size was calculated using the formula:

$$N = \frac{Z^2 \times P(1-P)}{D^2}$$

Where:

Z is the corresponding value of the standard deviation test statistics at known level of significance

P is the percentage of hormonal contraceptives side effect.

D is margin of error tolerated=5%

Given that:

Z= 1.96 at 95% confident limit

P= 41.7% from previous study, (Ezegwui *et al.*, 2011).

D= 0.05

$$N = \frac{(1.96)^2 \times 41.7\% (1-41.7\%)}{(0.05)^2}$$

$$= 1.96 \times 1.96 \times \frac{41.7}{100} \times \frac{(1-41.7)}{100} / 0.05 \times 0.05$$

$$= 371.49 \approx 371.$$

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

The addition of 10% attrition rate will make the sample size 408.

Sampling Method

The population of respondents that came for family planning, ANC and pre-clinical students (for ESUT-TH Parklane alone) in the three study areas during the period of the research were, ESUT-TH Parklane = 5680; Uwani General Hospital=1360; Udi General Hospital=560. A total of 410 respondents were selected from the study areas using the proportionate stratified sampling method in the heterogeneous population which resulted to 306, 73, 30 respondents respectively in the three centers. The respondents were selected based on the inclusion criteria.

Inclusion criteria:

1. Female respondents age 15 -49 years WHO, (2006)
2. Female respondents who willingly gave consent to participate in the study.

Exclusion criteria:

1. Female respondents below 15 years & above 49 years.

Data Collection

Interviewer administered questionnaires was shared to know the common types of hormonal contraception used, different side effects experienced by women on hormonal contraceptives and those that had used this method in the past. The reasons why some respondents refused to use this form of contraception in the three health facilities where the study was carried out was also investigated.

Ethical Considerations

All procedures were carried out according to a study protocol approved by the ethics committee of Enugu State Ministry of Health. Objective and nature of study were explained to the head of the family planning units in the three study areas and the participants as well. The participants consented to the study. Only the principal investigator had access to the information provided by the respondents.

METHOD OF DATA ANALYSIS

The collected data were sorted, coded and inputted in Statistical Package for Social Sciences (SPSS) version 25.0 for analysis. The results were presented in frequency tables. Chi-Square test was used to analyze the relationship between some socio-demographic characteristics (Age, Marital status, Educational level, Occupation) and hormonal contraceptive use. All analysis were done at 5% level of significance with $P < 0.05$ considered.

RESULTS AND DISCUSSION

Table 1 represents the socio-demographic characteristics of the study. Out of the 410 female respondents, majority of them were between 26 – 35 years (52.9%), followed by 19-25 years (20.7%) and the least respondents were between the ages of 46 – 49 years (3.9%). A greater number of respondents were married and stood at 72.9%. The predominant occupation of respondents who participated in the study was civil servants (23.3%), followed by traders (20.0%). Most of the women who participated in the study were educated up to tertiary level (58.3%) and 25.7% were educated up to the level of secondary school.

Almost all of the respondents were Christian (96.1%); 2.4% were Muslim; 1.0% was of traditional religion; while Atheist accounted for negligible 0.5%. The predominant sect was Catholic (54.2%), followed by Anglican (27.3%). The women were mostly Igbo (93.6%) because the study was conducted in Igbo land; Hausa women accounted for 3.2%; Yoruba 2.0%; and other tribes (1.2%). A majority of the respondents resides in Enugu Urban (79.5%) while 20.5% live in Enugu rural area.

Among the 410 respondents, 56.6% (232) have used one or more forms of hormonal contraceptives while 43.1% said they have not (Table 2). The most commonly used hormonal contraceptive was the birth control implants (Jadelle, Implanon, Nexaplanon etc) and accounted for 40.1%, followed by emergency hormonal contraceptives 26.3% and birth control injection (Noristerat, Subcutaneous Depot Provera, Sayanna Press), 24.6%.

Hormonal contraception is one of the common modern methods of family planning used by women of reproductive age in Nigeria. It is associated with some side effects which had brought some myth about its use among reproductive aged women in Nigeria and Enugu State is not an exception.

In the study the age group that used hormonal contraceptives most was women of 36 – 45 years (58.1%). This can be explained by fact that at this age range, a lot of women are married, have at least one child or have completed their family size, therefore the need for contraception to prevent unwanted pregnancy. It is also an age range with some degree of financial independence, vast reproductive knowledge that helps them to make the right decision affecting their reproductive health. The widows were the major users of hormonal contraceptives in the study (92.3%). It can be explained by the fact that they had lost their husbands and would

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

need contraception to prevent unwanted pregnancy and its complications with its associated financial burden. Women with Post graduate degree used hormonal contraceptives most (70.6%). This could be attributed to the level of their reproductive health knowledge. Interestingly Farmers were the most users of hormonal contraception in the study.

The study showed that 56.6% ($X^2=7.686$) of the study population had used one form of hormonal contraception in their reproductive years. There was significance difference in the use of hormonal contraception ($P=0.006$). 76.0% of respondent who used hormonal contraceptives had side - effects. This is in keeping with the study carried out in North Western Nigeria of Kano by Ibrahim *et al.* (2015), on "Oral contraceptive use among grand multiparous women" in which the major cause of non-use of contraceptive was fear of side effects (77.2%). 24% of the respondents did not experience any form of side-effect during the course and after removal of the hormonal contraceptives. It thus showed that some clients could take this form of contraception without experiencing any form of side-effect. 17.5% of respondents in the study that used hormonal contraception abandoned it because of various forms of side - effects. This prevalence is close to another study carried out in Enugu by Ezegwui *et al.* (2011), on "The discontinuation of implanon at family planning clinic of University of Nigeria Teaching Hospital (UNTH) Enugu, Nigeria in which 21.4% discontinued their implanon because of side effects.

Menstrual irregularity (Spotting/ excessive bleeding, inter-menstrual bleeding) accounted for the highest side- effect (44.4%) which is slightly higher than the study done in Aba South Eastern Nigeria by Chigbu *et al.* (2010), on 188 clients where 30.6% discontinued their injectable hormonal contraceptives because of prolonged and irregular menses.

The study showed two respondents (0.9%), who were not known hypertensives but with risk factors (family history) that had elevated blood pressure $\geq 140/90$ mmHg while using Norplant 2 (Jadelle), of which one insisted that the Jadelle be removed and after its removal, two weeks later the blood pressure was 130/80mmHg without anti-hypertensive. Estrogen increases the levels of fibrinogen, coagulation factors VII, VIII, and plasminogen activator inhibitor. Oral contraceptive use leads to decreased activated protein C resistance (APC resistance). The net effect of these procoagulant and anti-coagulant changes is small increase in coagulation;(Conard, 1999). Breast cancer accounted for 0.4% and was the least side effect experienced by respondents in the study. It was actually one respondent who had mastectomy for breast cancer and also had adjuvant chemotherapy. She was still seeing the surgical team during the time of the study for follow up. The study could not conclusively ascribe the breast cancer to the use of hormonal contraceptives because of other risk factors which needed to be investigated and ruled out before linking it to hormonal contraception.

A prospective study carried out in Denmark in 2017, reported breast cancer risks that is associated with recent formulation of oral contraceptive;(Morch *et al.*, 2017). This Denmark study showed that women that used combined oral contraceptive had a 20% increase in relative risk of breast cancer compared to women who had never used oral contraceptives. The risk varied from 0% to 60% depending on the type of combined oral contraceptive used. Women that had used combined oral contraceptive for 5 years or more have a higher risk of cervical cancer than women who had never used it. The Denmark study found a 10% increased risk for less than 5 years use; a 60% increased risk of 5 to 9 years use and a doubling risk with 10 or more years of use(Smith *et al.*, 2003). The Denmark study also found out that hormonal contraceptives have a protective effect on endometrial and ovarian cancer.

The study was able to demonstrate some myths (73.0%) surrounding the use of hormonal contraceptives from respondents in the three study areas. Fear of side effect was the most common (33.1%) while religious belief was the least (7.3%) and mostly the Roman Catholic respondents. 81.1% of respondents who used hormonal contraceptive in the study agreed to recommend to their friends & family relatives basically because of the benefits derived which outweighed the side - effects experienced. The benefits included very light menses, good child spacing, decreased menstrual cramps, affordability, increase in family finance. These benefits however, explained the importance of hormonal contraception for women in their reproductive age.

CONCLUSION

The respondents in the three selected hospitals in Enugu (ESUT -TH Parklane, Uwani and Udi General Hospitals) had good knowledge of hormonal contraception. The common types of hormonal contraception used in these facilities in descending others were: Birth control implants, emergency hormonal contraceptives, birth control injections etc & the least was birth control patch. The reasons behind decline in hormonal contraceptives use among women of reproductive age in these three facilities in Enugu were because of side effects and some myths (Fear of side effects, religious belief, ignorance etc).The study was able to establish that there was a significant side - effects (76.0%), though these side effects disappeared within weeks to months of usage and some were relieved by medical intervention. This study was able to find out that despite the side effects experienced by these women, greater percentage (69.8%) agreed that they would use it again and even recommend it to their friends and family relatives. Therefore, it is recommended that health personnel should adequately counsel clients in need of contraception and side effects should be spelt out to remove most the myths associated with contraception especially hormonal contraceptives. Also more media awareness on contraception should be encouraged through radio, television, social media and health talk on contraception in outreach programs in various communities. Government should increase provision of hormonal contraception most especially in the rural areas and semi-urban areas through government health facilities and also assist private health institutions involved in

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

provision of contraception through subsidy. Lastly, further researches on side effects of hormonal contraception should be encouraged in Nigeria.

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Table 1. Socio-Demographic Characteristics of the Respondents

Age	Frequency	Percent
15-18	18	4.4
19-25	85	20.7
26-35	217	52.9
36-45	74	18.0
46-49	16	3.9
Total	410	100.0
Religion		
Christianity	394	96.1
Islam	10	2.4

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

Traditional	4	1.0
Other	2	0.5
Total	410	100.0
Sect		
Catholic	222	54.2
Anglican	111	27.3
Pentecostal	71	17.2
Others	6	1.3
Total	410	100.0
Marital Status		
Single	90	22.0
Married	299	72.9
Widowed	13	3.2
Divorced	8	2.0
Total	410	100.0
Educational Level		
No formal educational	13	3.2
Primary education	18	4.4
Secondary education	106	25.8
Tertiary education	239	58.3
Postgraduate	34	8.3
Total	410	100.0
Occupation		
Student and apprentice	80	19.6
Farmer	17	4.0
Trader	82	20.0
Civil servant	96	23.3
Public servant	68	16.8
Unemployed	26	6.2
House wife	26	6.4
Others(Artisans, Nannies)	15	3.7
Total	410	100.0
Tribe		
Igbo	383	93.6
Hausa	14	3.4
Yoruba	8	2.0
Others	5	1.2
Total	410	100.0
Residence		
Enugu urban	326	79.5
Enugu rural	84	20.5
Total	410	100.0

Table 2. Hormonal Contraceptive Use by Respondents

Hormonal contraceptives use	N	Percent
Birth control pills	22	9.5
Birth control injection	57	24.6
Birth control implants	93	40.1
Emergency hormonal contraceptives	61	26.3

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

Hormonal intrauterine devices	25	10.8
Birth control patch	2	0.9

Multiple responses

The age range of 36 – 45 (58.1%) years was the major group that used hormonal contraceptive followed by 19 – 25 years age range (57.6%), (Table 4.3). There was a significant difference ($P=0.000$) in the use of hormonal contraception in the different age groups.

Table 3. The Cross Tabulation between Age and Use of Hormonal Contraceptives

Age				Percent	X ²	P value
	Yes	No	Total			
15-18	8	9	17	47.1	326.220	0.000
19-25	49	36	85	57.6		
26-35	123	93	216	56.9		
36-45	43	31	74	58.1		
46-49	9	7	16	56.3		

Table 4 represents cross tabulation between marital status and use of hormonal contraceptives. The table showed that the widows (92.3%) were the major users of hormonal contraceptives followed by the married women (56.9%). There was an uneven use of hormonal contraception by their marital status ($P=0.000$).

Table 4. Cross Tabulation between Marital Status and Use of Hormonal Contraceptives

Marital status	Yes	No	Total	%	X ²	P-value
single	47	42	89	52.8	540.995	0.000
married	169	128	297	56.9		
widowed	12	1	13	92.3		
divorced	4	4	8	50.0		

Hormonal contraceptives use was most common with respondents with post graduate degree (70.6%) followed by respondents with non-formal education (69.2%), (Table 5). There was uneven use of hormonal contraception on educational level ($P=0.000$).

Table 5. Cross Tabulation between Educational Level and Use of Hormonal Contraceptives

Educational level	Yes	No	Total	%	X ²	P- value
no formal educational	9	4	13	69.2	441.485	0.000
primary education	8	10	18	44.4		
secondary education	68	37	105	64.8		
tertiary education	121	115	236	51.3		
Postgraduate	24	10	34	70.6		

Table 6 represents cross tabulation between occupation and hormonal contraceptives use. Interestingly farmers (68.8%) were the major users of hormonal contraceptives in this study followed by the unemployed (64.0%). There was significant difference in hormonal contraceptives use by respondents occupation ($P=0.000$).

Table 6. Cross Tabulation between Occupation and Hormonal Contraceptives Use

Occupation	Yes	No	Total	%	X ²	P- value
student and apprentice	40	38	78	51.3	151.327	0.000
Farmer	11	5	16	68.8		
Trader	45	35	80	56.3		
civil servant	57	37	94	60.6		
Unemployed	16	9	25	64.0		

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

house wife	16	10	26	61.5
Others	6	9	15	40.0

These were the reasons respondents who did not use hormonal contraception in the study gave for not using it, (Table 7). (1). Fear of side effects which accounted for 33.1%. (2). Because of their religious belief which accounted for 7.3%. (3). Majority of the respondents was Christians of Roman Catholic sect that does not believe in modern method of family planning. (4). Because of factors such as ignorance, fear of cancer, fear of contracting sexual transmitted infection, because they are not married, because they need to attain a level of family size before use. All these reasons fell under the option 'others' which accounted for 32.6%.

In total 73.0% (130) of respondents refused to use hormonal form of contraception basically for one or more of these reasons (Myth).

27.0% (48) of the respondents were using non-hormonal form of contraception.

Table 7. Reasons for Not Using Hormonal Contraceptives by Some Respondents

	Frequency	Percent
Fear of side effect	59	33.1
It is against my religious belief	13	7.3
Use of other contraceptives	48	27.0
Others	58	32.6
Total	178	100.00

Table 8 represents the general side effects of hormonal contraceptive experienced by respondents. Among the study population 76.0% of the respondents who used hormonal contraceptives had side effects while 24.0% had no side effects. Irregular bleeding/spotting/excessive bleeding was the most common side effect (44.4%), followed by weight gain (42.7%), difficulty in seeing menses (21.6%) and the least being cervical/breast cancer (0.4%).

Table 8. General Side Effects Of Hormonal Contraceptives

	N	Percent
Irregular bleeding/ spotting and excessive bleeding	103	44.4
Weight gain	99	42.7
Depression /anxiety and mood changes	33	14.2
Difficulty in seeing menses during and after use	50	21.6
Difficulty in getting pregnant after use	16	6.9
Increase incidence of fracture and bone disease	9	3.9
Increase incidence of sexually transmitted diseases	28	12.1
Headache /migraine/ blurred vision	43	18.5
Breast tenderness	38	16.4
Low libido or sexual desire	33	14.2
Heart attack/ stroke /hypertension	2	0.9
Chest pain /leg pain	14	6.0
Acne/ pimples	13	5.6
Nausea and vomiting allergy	23	9.9
Abdominal bloating	46	19.8
Cervical and breast cancer	1	0.4
Multiple responses		

The respondents that used the birth control injection complained of pain on administration (47.4%), followed by frequent injection (36.8%), (Table 9).

Majority of respondents that used hormonal implants complained of pain on both insertion and removal (45.2%) followed by complaints such as scar at insertion site, wound, infection etc represented as 'others' (30.1%), (Table 10).

The Reported Side Effects of Hormonal Contraception by Women of Reproductive Age in Selected Hospitals in Enugu: Truth or Myth

Table 9. Specific Side Effects Common With Birth Control Injection

Variables	Frequency	Percent
Pain at injection site		47.4
	27	
Injection abscess	7	12.3
Frequent injection	27	36.8
Delayed return of fertility	2	3.5
Total	57	100.0

Majority of respondents that used hormonal implants complained of pain on both insertion and removal (45.2%) followed by complaints such as scar at insertion site, wound, infection etc represented as 'others' (30.1%), (Table 10).

Table 10. Specific Side Effects Through Administration of Hormonal Implants

Pain on insertion and on removal	42	45.2
Difficulty on removal	16	17.2
Dislodgment from site of insertion	7	7.5
Others (scars, infection, etc)	28	30.1
Total	93	100.0

Table 11 represents how respondents treated the side effects they experienced. Among these respondents (47.4%) of them had to see their health personnel where treatment such as microgynon(COCP), tranexamic acid, non-steroidal anti-inflammatory drugs was given before the side effects stopped. Some of the respondents said the side effects disappeared on its own within three months without treatment (35.1%).

Table 11. How Respondents Managed Their Side Effects

Cases	Frequency	Percent
Spontaneous resolution after some months	60	35.1
visited doctor for treatment	81	47.4
stopped the pills on my own	10	5.8
asked doctor for total removal	20	11.7
Total	171	100.0

Table 12 represents benefits respondents derived from use of hormonal contraceptives.

A greater percentage of respondents had good child spacing (69.8%) and it really helped them in their family finance (50.4%). Among the respondents that used hormonal contraceptives, 81.1% agreed that they would recommend to their friends and relatives because of its numerous benefits while 18.9% said they would not do so because of the side effects they experienced. A greater number of respondents 69.8% agreed that side effects would not discourage them from further use.

Table 12 Benefits of Hormonal Contraception

Responses	Frequency	Percent
Very light menses	43	18.5
Good child spacing	162	69.8
Decreased menstrual cramps	33	14.2
Low cost	92	39.7
Proper family finance Planning	117	50.4
No history of cancer following long term use.	64	27.6
Multiple responses		