

# Personal choices and use of contraception by Nigerian trainee gynaecologists: Any influence on counseling practices?

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## ABSTRACT

Physicians with gynaecological training often have correct information about contraceptive technologies, their effects and benefits. Their personal choices may affect their practice. The objectives of this study are to find out what contraceptives Nigerian trainee gynaecologists use, and if this affects the way they counsel their clients. This was a cross-sectional survey. Participation was voluntary and 150 trainees were to fill out a pretested, self-administered questionnaire eliciting general demographic information, academic post and years of training, information on personal contraceptive use and choices, and how it may influence their practices. Analysis was done using the statistical package for social science (SPSS) computer software, version 20. Descriptive analysis was performed, using frequency tables. Chi-square test was used to compare variables and assess significance. P value of <0.05 was considered significant. There was a response rate of 62%. About 25.8% of respondents were not currently using any form of contraception and 53% were currently using modern methods of contraception, most commonly barrier methods and intrauterine devices. There was poor uptake of male sterilization. Twenty four respondents (25.8%) had several objections to contraceptive use. The choice of contraception used was significantly associated with gender. Sixteen respondents (17.2%) felt their personal choices may affect how they counsel patients and prescribe contraceptive agents. The level of respondents and number of children significantly affected counseling practices. In conclusion, trainees prefer to use natural forms of contraception. However, larger studies will be required to verify that personal objections to contraceptives introduce bias to contraceptive counseling practices.

**Keywords:** Contraception, personal choices, gynaecologists, counseling practices.

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## INTRODUCTION

Nigeria generally has high maternal mortality rates and low contraceptive uptake rates (National Population Commission Nigeria, 2008). The 2008 Demographic and Health Survey (NDHS) showed that use of regular contraception was 15% in 2008, use of modern contraception was 10% but married women still had a

20% unmet need for family planning (National Population Commission Nigeria, 2008). The 2013 Demographic and Health Survey (NDHS) also shows similar trends in contraceptive use (National Population Commission Nigeria, 2013).

Low levels of awareness, myths and misinformation

about side effects of contraception among other factors contribute to the low uptake of contraception (Monjok et al., 2010; Ekabua et al., 2009; Olugbenga-Bello et al., 2010). Physicians, especially those with added training in gynecology, are more likely to be aware of the wide range of contraceptive technologies available, their effects and benefits. Hence they may be useful channels to dispel myths on contraception by proper patient education. Good medical practice guidelines state that doctors must not express personal beliefs that may exploit their patient's vulnerability or cause them distress (General Medical Council, 2013). It however recognizes that doctors have personal values that affect their day-to-day practice, but they must try to disregard their own views and give unbiased medical advice (Olugbenga-Bello et al., 2010).

A study in Belgium shows that trust-based counseling of women by their gynaecologists made many women select a different contraceptive method, or when they were previously undecided, they usually opted for the method their gynaecologist recommended (Merckx et al., 2011). Another study showed that female physicians' clinical advice might differ from their personal practices, but as women physicians become more prevalent, their contraceptive choices could influence those of their patients (Frank, 1999). Whereas in Germany and Austria, even though female physicians used extended-cycle contraceptive pills (COCs), it did not impair their prescribing habits (Wiegratz et al., 2010).

Though multiple factors influence the acceptance, choice and utilization of contraceptives (Bukar et al., 2013), our own experience in Nigeria shows that patients expect their doctor's opinion on the choice of contraception to use and hardly question it, though this is gradually changing as people get more educated and more aware. A study in Gombe, Nigeria demonstrated a low number of respondents having the opinion that women have an independent right to contraceptive acceptance, choice and practice and echoed the importance of male involvement in contraception decision-making (Bukar et al., 2013). With this background, our study set out to find out what contraceptives Nigerian gynaecologists use, and if this affects their clients in any way.

## METHODOLOGY

This was a cross-sectional survey done among resident doctors attending a national update course in Obstetrics and Gynaecology, organized by the West African College of Surgeons in Abuja, March 2009. The cohort of trainee gynaecologists who assembled for an annual update course provided a mixed sample population representative of major ethnic groups from all over Nigeria. Permission was gotten from the organizers and participation was voluntary. We developed a self administered questionnaire to elicit general demographic information (such as age, sex, ethnicity etc), number of children and last child birth, academic post and years of

training, information on personal contraceptive use and choices, and how it may influence their practices. Analysis was done using SPSS computer software, version 20. Each question was analyzed based on the number of respondents (N). Some information was incomplete as not everyone responded to all questions and numbers of respondents are indicated for relevant results. Descriptive analysis was performed, using frequency tables. Using the chi-square test, several factors (demographic factors, reproductive factors, level, number of children etc) were tested to see if they significantly affected personal choice, use and counseling practices of respondents. P value of <0.05 was considered significant.

## RESULTS

About 150 trainee gynaecologists attended the course and were given questionnaires to fill but only 93 questionnaires were returned giving a response rate of 62%.

There were more male than female respondents with a male; female ratio of about 3.4:1. Most of the respondents were within 30 to 39 years of age with a mean age of 38 years, minimum age of 30 years, maximum of 54 years and standard deviation of 4.858. While respondents' spouses were also mainly within the 30 to 39 year age group (48.4%), mean age 35, minimum age 23, maximum 65 and standard deviation of 7.757. Most respondents were married (87.1%) and Christian (81.7%). Among the three major ethnic groups, Hausas were the least represented while there were a lot of respondents from other minor ethnic groups such as Tiv, Ijaw, Ibibio etc. Most respondents had at least one child. Demographic characteristics of respondents are summarized in Table 1.

Respondents included 4 medical officers (4.3%), 62 registrars (66.7%) and 27 senior registrars (29%). They had varying years of experience; 32 respondents had 1 to 3 years experience (34.4%), 22 had 4 to 6 years of experience (23.7%), 37 had more than six years experience 39.8%) while there was no response from two respondents (2.2%).

Twenty four respondents (25.8%) were not currently using any form of contraception. Fifty three (57%) were currently using modern methods of contraception (Table 2). Twelve respondents (12.9%) while on contraception had experienced side effects such as irregular bleeding, Breast tenderness, failure, leucorrhoea and others like skin irritation. None of the factors tested significantly affected current contraceptive use (P value  $\geq$  0.05) of respondents.

Twenty four respondents (25.8%) had several objections to the use of different forms of contraception, fifty five (59.1%) did not have any objections and fourteen responses were missing to this question (15.1%) as shown in Table 3. Table 4 shows that the choice of contraception used was significantly associated with gender (Pearson's chi square = 16.973, degree of

**Table 1.** Demographic characteristics of respondents.

Characteristic	Frequency (N = 93)	Percentage (Total = 100%)
Age (years)		
30-39	60	64.5
40- 49	32	34.4
50-59	1	1.1
Age of spouse (years)		
20-29	17	18.3
30-39	45	48.4
40-49	16	17.2
50-59	2	2.2
≥60	1	1.1
Missing	12	12.9
Gender		
Male	71	76.3
Female	22	23.7
Marital status		
Married	81	87.1
Single	11	11.8
Widowed	1	1.1
Religion		
Islam	17	18.3
Christianity	76	81.7
Ethnic group		
Hausa	7	7.5
Igbo	21	22.6
Yoruba	23	24.7
Others	42	45.2

**Table 2.** Current and past contraceptive use by respondents or their spouses.

Contraceptive method	Respondents/spouses	
	Past use (%)	Current use (%)
None	22 (23.7)	24 (25.8)
Natural	4 (4.3)	16 (17.2)
Barrier	17 (18.3)	15 (16.1)
Oral contraceptive pills	1 (1.1)	3 (3.2)
Injectables	1 (1.1)	3 (3.2)
Implants	2 (2.2)	4 (4.3)
Intrauterine devices	5 (5.4)	10 (10.8)
Permanent methods	0 (0)	2 (2.2)
Missing data	41 (41.1)	16 (17.2)
Total	93 (100)	93 (100)

freedom = 7, P value = 0.018). Not as many males were using contraception compared to female respondents.

Males mostly preferred barrier methods and no male favoured permanent methods of contraception. Female

**Table 3.** Reasons for the choice, as well as objections to various types of contraception by respondents.

Reasons given by respondents	Frequency (%)
Choice of contraception	
Convenience	26 (28)
Safety	15 (16.1)
Effectiveness	7 (7.5)
Religious	1 (1.1)
Social	3 (3.2)
Missing response	41 (44.1)
Objection to contraceptive use	
Irregular bleeding	8 (8.6)
Not convenient	5 (5.4)
Not effective	4 (4.3)
Moral/religious	1 (3.2)
Others (delays fertility, affects intercourse)	4 (4.3)
Missing response	69 (74.2)

**Table 4.** Gender as a factor affecting respondent's contraceptive choice.

Form of contraception (N = 77)	Gender	
	Male (%)	Female
None	21 (36.8)	3 (15)
Natural	12 (21.1)	4 (20)
Barrier	13 (22.8)	2 (10)
Oral pills	1 (1.8)	2 (10)
Injectables	2 (3.5)	1 (5)
Implants	1 (1.8)	3 (15)
Intrauterine devices	7 (12.3)	3 (15)
Permanent methods/sterilization	0 (0)	2 (10)

**Table 5.** Factors affecting respondents counseling practices.

Factor	Affects your counseling?		
	Yes (%)	Do not know (%)	No (%)
Number of children (N = 59)			
0	2 (25)	2 (25)	4 (50)
1-4	11 (22.9)	1 (2.1)	36 (75)
>4	3 (100)	0 (0)	0 (0)
Level (academic post) (N = 59)			
Medical officer	0 (0)	1 (50)	1 (50)
Register	8 (21.6)	0 (0)	29 (78.4)
Senior registrar	8 (40)	2 (10)	10 (50)

respondents used all the forms of contraception but mostly preferred the use of natural contraceptive methods (17.2%).

Table 5 shows that sixteen respondents (17.2%) felt their personal choices may affect how the counsel patients and prescribe contraceptive agents, three (3.2%) were unsure, forty (40.3%) felt their counseling and prescription patterns would not be affected, while 34 (36.6%) did not respond. Some of the ways respondents felt it could influence their practices were: omitting a method while counseling, emphasizing side effects to discourage clients especially those that are very young, or have completed their families, encouraging a particular method, or mentioning what the respondent uses. The level of respondents and number of children significantly affected counseling practices (Table 5). The more children respondents had, the more likely they were to

have their counseling practices influenced (Pearson's chi square = 16.220, degree of freedom = 4, P value = 0.003). Senior registrars were however less likely to have their counseling practices influenced by personal choices than registrars and medical officers (Pearson's chi square = 14.485, degree of freedom = 4, P value = 0.006).

## DISCUSSION

This study reflects a genuine knowledge-based attitude of respondents towards modern contraception as opposed to myths. In this study, female trainees used contraception more than their male counterparts. This may be due to a more compelling need to avoid unplanned pregnancy during training. Male trainees may not entertain such fears. This is also in line with the

general trend in most places in the world where females are almost synonymous with contraceptive use.

Most trainees preferred the use of natural methods of contraception; 21% of males and 20% of females. The fact that a comparable proportion of respondents have several objections to contraceptive use may explain a preference for the natural methods. This is however much higher than in the general populace where about 5% are estimated to use traditional (rather than modern) forms of contraception (National Population Commission Nigeria, 2008). Perhaps the small sample size may account for this, though doctors are not detached from their environments and have similar cultures and values to the societies they come from. Knowledge does not always translate to a logical behavior change (Gordon, 2002). Meanwhile, clients that are not educated may find it difficult to use natural fertility awareness methods. One study among infertile women showed that only 28 (32.2%) out of the 87 subjects knew their menstrual cycle length, 39.1% (34/87) had an idea of their ovulatory period, and of 18 (20.7%) subjects that knew the signs of ovulation, 13 (72.2%) of them do experience signs of ovulation (Adesiyun et al., 2011).

Females also used the whole range of available contraceptive methods including tubal ligation while no male used male sterilization. This is quite typical in Nigerian culture. Out of 17,846 new clients at the Jos University Teaching Hospital over a period of more than ten years, only 9.5% were male, and only ten males had vasectomy (Mutahir and Pam, 2008). A previous study among Nigerian resident doctors in the field of obstetrics and gynaecology showed that despite good theoretical knowledge of vasectomy, most were convinced that the average Nigerian male will not accept vasectomy, less than half would opt for vasectomy or urge their husbands to, and very few counseled for vasectomy as compared to bilateral tubal ligation (Ebeigbe et al., 2011). Our findings are also in keeping with a study in the United States, where physicians were more likely to use intrauterine devices, diaphragms, or condoms, and less likely to use female or male sterilization than when compared to the general population (Frank, 1999).

In this study and among respondents using modern forms of contraception, the use of barrier and intrauterine methods ranked highest. Whereas, among the Nigerian populace most commonly prefer the use of injectables (National Population Commission Nigeria, 2008; National Population Commission Nigeria, 2013), but this varies widely. Perhaps this is because doctors are more likely to be aware of the dual advantage of barrier methods; to protect against pregnancy, and most sexually transmitted infections, and may also want to avoid the side effects of hormonal contraception.

Some respondents identified themselves as “medical officers”. Perhaps these are those who have passed an examination stage of the residency programme but for

one reason or the other are not currently designated in their institution as a “resident”; such as those that have exceeded the time allowed for residency. It is however not surprising that senior registrars were less likely to have their counseling practices influenced by personal choices than registrars and medical officers. This is probably because they are better trained and have more experience than their juniors. It is however not clear why those with a higher number of children (especially >4) were more likely to have their counseling practices influenced. Residency training is difficult and becomes more challenging when there are more children to look after. They probably have used a wider range of contraceptive methods in child spacing and had firsthand experiences which influence their counseling.

This study is however at variance with the Canadian study which found that physician gender was associated with attitudes to diaphragm prescription, and also influenced perceptions relating to contraceptive eligibility, efficacy and adverse effects (Russell and Love, 1991).

### Limitations

This study is limited by the use of convenient sampling and its relatively small sample size has limited power to detect statistically significant differences.

### Conclusion

Despite in-depth contraceptive knowledge, trainee gynaecologists in this study preferred natural method of contraception and when modern methods were utilized, barrier methods ranked highest. Male trainees are however unlikely to adopt male sterilization as is true of the general Nigerian populace.

Personal objections to contraceptive use may introduce some bias to contraceptive counseling practices. Larger studies are required to verify these findings among practicing gynaecologists and general physicians, as this may have a negative effect on contraceptive uptake by clients. There should be better awareness of good medical practice guidelines while newer contraceptive technologies approaching the ‘ideal’ are highly desirable.

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