

Effects of Body Image and Marital Support on Hormonal Contraceptive Use Anxiety

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Abstract

Population control is a serious threat to many nations including Nigeria. With the projections of census experts, except a conscious family planning is instituted, the future may be bleak. Given this background, this study evaluated marital support and body image as factors that affect married women's anxiety towards hormonal contraceptive use. The participants were 209 married women whose ages ranged from 24 years and 39 years with a mean age of 30.50yrs and a standard deviation of 2.40yrs. multi-stage sampling technique (purposive, cluster and simple random sampling) was applied in the sampling and selection method. Anchored on the theory of planned behaviour, the design was factorial design using 2-Way ANOVA as statistics while Symptoms check list, Spousal support scale and Dresden body image questionnaire (DBIQ) were used for data collection. Findings indicated that the initial group differences observed in hormonal contraceptive anxiety between participants with high marital support and those with low marital support was significant at $F = 3.6^*$, $p < .05$ ($N = 209$). Also, the result revealed that women with healthy body image significantly had lower hormonal contraceptive use anxiety than their counterparts with unhealthy body image at $F = 4.8^*$, $p < .05$ ($N = 209$). Equally there was interaction effect between marital support and body image on hormonal contraceptive use anxiety at $F = 21.7^*$, $p < 0.05$ ($N = 209$). Mass education and sensitization was recommended on the importance of harmonious marital unions and proper self-image as factors which can boost wives' hormonal contraceptive use.

Key Words: Anxiety, body image, hormonal contraceptive, pills, implants,

Introduction

The global population is currently 7.9 billion and is expected to increase by more than 2 billion in the next 30 years by 2050. As much as it is a positive growth, the attendant problems of managing population bloat is threatening to stakeholders; thus, the global population has become more than a problem because of its obvious implications not limited to; increasing hungry population (Stavi et al., 2021), increasing homelessness (Ali et al., 2020) and increasing joblessness with more people chasing fewer available jobs (Oshora et al., 2021). In all, the increasingly global hyper population has found more people disadvantaged not by a fault of theirs, but by lack or limited resources orchestrated by scrambling by many due to population bloat (Ali et al., 2020). In the face of the consequences of hyper population, global response has been to manage birth control through family planning and to use it as a tool to reduce the surging population.

Birth control is a family planning method or device which is used to control and prevent pregnancy thereby limiting number of births. Birth control is a preventive technique aimed to preventing fertilization and making it difficult to occur (Tran et al., 2020) or terminating its early occurrence. One of the dividends of birth control campaigns is its global adoption and the flexibility of family planning measures as means to managing population control. Effectiveness each type of birth control is dependent on many associated factors including how it is used, when it is applied, and what it is used for. The efficacy of each type of birth control is generally expressed as the percentage of women who become pregnant using a given method during the first year (Manzer & Bell, 2021) and sometimes as a lifetime failure rate among methods with high effectiveness, such as tubal ligation.

In Nigeria like other developing countries in Africa, poor birth control and population management has emerged as a serious threat to her socio-economic advancement. More so, with Nigeria's very visible weak institution, health infrastructure, poor legislation on family planning, and the challenges orchestrated by lack of birth control policy; the problems associated the use of different types of birth control and the socio-cultural barriers associated with them have become topics of discussion among

the public (Etokidem et al., 2017). One of the commonest discussed themes regarding the efficacy of each type of birth control technique outside its cost and efficacy is the unknown consequences (long and short term) or the health outcomes of its usage such as the psychological outcomes (e.g., anxiety) associated with each type of birth control.

There are many types of birth control optimized these days. Some of them include barrier methods, oral contraceptive, hormonal birth control (hormonal contraceptive), intrauterine devices (IUDs), sterilization, and behavioral methods etc which are used before or during sex while emergency contraceptives are effective for up to five days after sex (Mellors, 2019). This study is interested in hormonal contraceptive.

There are many problems which plague hormonal contraceptive use including religious and socio-cultural barriers, economic factors as regards the cost of the contraceptive, psychological distress such as: fear, phobia, anxiety, depression, and body image, ease of use, perceived efficacy and product use satisfaction. The current study considers marital support and perception of body image as the leading problem of anxiety in the use of hormonal contraceptive. For instance, the study considered the study by Barden-OFallon et al. (2021) on the return to pregnancy after hormonal contraceptive discontinuation to become pregnant of West and East African populations as inadequate to explain the causes or determinants of users anxiety of becoming pregnant after the use of the method. In as much as this study was done in West and East Africa, the study failed to highlight the challenges of users in Nigeria.

Also, Ndolas et al. (2017) study on partner support for family planning and modern contraceptive use in Luanda, Angola equally failed to establish whether partner support caused anxiety among intending users. The study did not also evaluate the dimensions of concern for body image for the intending users. The population of their study significantly differs from the Nigerian population and thus creates socio-cultural differences which may exist in the behavioural patterns of the two populations. These lapses further created gaps which this study attempts to fill.

Furthermore, Vincent (2020) study on the influence of socio-demographic variables on the choice of contraceptives among women in Imo State, Nigeria failed to establish in

specific terms the types of contraceptives in view of this study which focused only on hormonal contraceptive. Hence, it is difficult to relate their findings to the current study. Also, their study was on socio-demographic factors and did not consider psychological factors such as the effects of marital support and body image in hormonal contraceptive use anxiety. The shortcomings of Vincent's study equally created gaps in literature which will be filled by the current study.

Review

Hormonal Contraceptive

Hormonal contraceptive is birth control methods that act on the endocrine system (French & Meltzer, 2020). Almost all methods are composed of steroid hormones, (although in India one selective estrogen receptor modulator is used). The original hormonal method was a combined oral contraceptive pill although many other delivery methods have been developed. The oral and injectable methods are by far the most popular. Hormonal contraception is highly effective especially when taken on the prescribed schedule, users of steroid hormone methods experience pregnancy rates of less than 1% per year while the perfect-use pregnancy rates for most hormonal contraceptives are usually around the 0.3% rate or less (Bradshaw et al., 2020). Currently, available methods can only be used by women; the development of a male hormonal contraceptive is an active research area. There are two main types of hormonal contraceptive formulations: combined methods which contain both an estrogen and a progestin, and progestogen-only methods which contain only progesterone or one of its synthetic analogues (progestins). According to Herrera et al. (2019), the combined methods work by suppressing ovulation and thickening cervical mucus; while progestogen-only methods reduce the frequency of ovulation, most of them rely more heavily on changes in cervical mucus, however, side effects is different for the different formulations.

Although, hormonal contraception has mild side effects in relation to different users (French et al., 2020; Bradshaw et al., 2020; Herrera et al., 2019) in comparison to other birth control measures, it has high efficacy of 0.03% (in the perfect use) pregnancy rate

per year among users and less than 1% for typical use. The efficacy of each type of birth control and minimal side effects usually propels its use and adoption by couples. This quality has propelled hormonal contraceptive acceptance and use in Western countries. However, it is surprising that in Nigeria, the result is not same (Mac-Aworu et al., 2020; Aina et al., 2019). In the views of the researcher, it is worrisome that despite the popularity and efficacy of hormonal contraceptives in Western world, its use and adoption by Nigerians remain minimal. The researcher therefore contends that the cause may be because of the anxiety about the unknown consequences which may be associated with the use of hormonal contraceptives.

Anxiety and Hormonal Contraceptive Anxiety

Anxiety is nervousness, apprehension and uneasiness regarding unknown outcome which the sufferer beliefs to be detrimental to his or her life and progress (Bashaa & Almeqrenb, 2020; Rudaz et al., 2017). Usually, the sufferer usually feels that the unknown outcome will be disadvantageous to them or unbeneficial. Anxiety towards the use of hormonal contraception is nervousness and apprehension regarding the health outcome of the use or adoption of hormonal contraceptive as a method of birth control (Siddall & Emmott, 2021). Usually, the uneasy apprehension stems from abnormal fear of the negative long-term effects of hormonal contraceptives in effect that its use and outcomes is not entirely known to Nigerians (Odusolu & Eyong, 2020).

There are many causes of anxiety regarding the use of hormonal contraceptive (Adedini et al., 2021). Some of them include but not limited to: lack of knowledge about the hormonal contraceptives, low levels of education, religious factors, socio-economic factors, marital support, and body image among others. The causes of anxiety are dependent on psycho-sociological factors peculiar to each individual. This study will focus on the effects.

Marital Support

Marital or spousal support is emotional support including sharing information to communicate with the family, appreciation (approving and appreciating the things that family members do), social network support (having the responsibility to be a part of a

group), approval support (supporting the family members), and altruistic support (devotion) (Yildirim, 2004).

Marital support in the case of hormonal contraceptive use refers to husband 's/partner's (primary because hormonal contraceptive currently has only female version) understanding, encouragement, motivation, tolerance and support for the use of family planning techniques (Ndola et al., 2017). Marital support may influence a women's modern contraceptive use either positively or negatively. The important issues of marital support in contraceptive use are the level and quality of couple's communication and shared values as regarding family planning (Bashaa & Ameen, 2020). Rarely do couples with history of intimate partner violence work together on contraceptive use (Adedini, 2021). This implies that wives use of hormonal contraceptive may be affected by whether they get support from their husbands and when this support is not available, anxiety may trail the use of any contraceptive including hormonal contraceptive. It is not only marital support that can cause anxiety in wives use of hormonal contraceptive; the perception of their body image may also lead to anxiety.

Body Image

Body image refers to as women's level of satisfaction with her body size/shape as measured by the body image acceptance and action questionnaire (BI-AAQ) (Sandoz & Wilson, 2006).

Body image refers to as women's level of satisfaction with her body size/shape (Sabiston et al., 2019). Body image is also seen as personality reactions of individuals regarding the type of body shape/weight they have including their perceptions, attitudes and emotions regarding such body types not minding whether they are real or imagined (Robertson et al., 2021). The problem associated with body image is that the perception whether real or imagined precipitate body dissatisfaction with a lot of psychological problems including anxiety (He et al., 2021). One of the major concerns of body image in contraceptive use is that there is apprehension that the contraceptive may lead to undesired weight gain which will distort body image. For this reason, there

may be anxiety among potential uses regarding the use of hormonal contraceptive use as they fear it may distort their perceived body image.

In consideration the contentions above, this study argues that the level of marital support and the perception of body image may affect the use of hormonal contraceptive among wives in Anambra State. Given the stated problem of the study, the following pertinent questions arise to guide the study:

1. Will marital support affect hormonal contraceptive use anxiety among married women in Anambra State?
2. Will body image affect hormonal contraceptive use anxiety among married women in Anambra State?
3. Will there be interaction effect between marital support and body image on hormonal contraceptive use anxiety among married women in Anambra State?

Method

Participants

The researcher made use of 209 married women (those within child bearing age) who are attending clinical sessions (antenatal, gynecology session etc) in selected public hospitals in Anambra State. The ages of the participants ranged from 24 years and 39 years with a mean age of 30.50yrs and a standard deviation of 2.40yrs. Multi-stage sampling technique (purposive, cluster and simple random sampling) was applied in the sampling and selection methodology. The researcher with the aid of letter of introduction from the Department of Psychology was able to obtain permission from the hospital management to carry out the study. Demographic particulars of the participants revealed that 143 participants were multigravida with 1-3 children whereas 51 participants were primigravida with a child, 15 participants were expectant mothers and 8 were multigravida with 4-6 children. In terms of educational qualification, participants with Ordinary level education certification were 74, those with NCE/ND were 68, and those with HND/Bachelor's degree were 43. Also, there were participants with Master's degree who

were 11, 13 participants declined to state their educational qualification. From the demographic description, the sample could say to be fairly educated and at the peak of child bearing age.

Instruments

For data collection in this study, 3 sets of instruments were used for the study – Symptoms check list to measure anxiety, Spousal support scale to measure marital support and Dresden body image questionnaire (DBIQ). In addition, demographic variables such as gender, age, marital status, educational background were included in the overall instrument used in the study.

Spousal Support Scale

Spouse Support Scale (SSS) was used to measure marital support. SSS which aims to measure the support that spouses receive from each other was developed by Yildırım (2004). It is a 3-point Likert-type scale and consists of 27 items. SSS consists of four factors such as emotional support (9 items, e.g., my spouse makes nice jokes), financial and information support (7 items, e.g., my spouse takes care of any problems about our home), appreciation support (8 items, e.g., my spouse accepts me with my strengths and weaknesses), and social interest support (3 items, e.g., my spouse communicates with me). Participants indicate their responses on a 3-point scale (3 ¼ strongly agree, 1 ¼ strongly disagree). It has a total score and according to scoring of the SSS, minimum score is 27 and maximum score is 81. The high score of the scale refers to high level of support that is received from the spouse of the individual who filled the scale. For this study reliability analysis during the pilot test revealed that Cronbach's was found to be .94 for this study.

Dresden Body Image Questionnaire

The Dresden Body Image Questionnaire (DBIQ) is a 35-item scale with positively and negatively worded items (reversely coded) that consists of five subscales: body acceptance (e.g., I wish I had a different body), vitality (e.g., I am physically fit), physical contact (e.g., I do not like people touching me), sexual fulfilment (e.g., I am very satisfied with my sexual experiences), and self-aggrandizement (e.g., I use my body to attract attention). Level of agreement is scored on a 5-point Likert scale ranging from 1 = not at all to 5 = fully. Higher

scores indicate a more positive body image. The development of the DBIQ was based on factor analytic evaluation of three German questionnaires measuring body image, namely the Fragebogen zum Körperbild (FKB-20), the Fragebogen zur Bewertung des eigenen Körpers (FBeK) and the Frankfurter Körper Konzept Skalen(FKKS). In a German non-clinical sample (n = 418), Cronbach's α for the subscales were: body acceptance .93, vitality .94, physical contact .83, sexual fulfillment .91, and self-aggrandizement .81. Correlations between the subscales varied between $r = .37$ (sexual fulfillment and self-aggrandizement) and $r = .65$ (body acceptance and vitality), indicating the overlap between the subscales to be small to medium. A confirmatory factor analysis was conducted in a sample of 560 German patients with psychosomatic disorders (CFI = .90; RMSEA = .06, other fit indices not available). A study on 505 students (M = 21.64, SD = 2.14) using a Flemish Dutch translation, somewhat different from the translation presently used, reported Cronbach's α for the subscales between .77 and .90. Correlations between the subscales varied between $r = .13$ and $r = .59$. In the present Dutch sample Cronbach's α for the subscales varied from $\alpha = .83$ for self-aggrandizement to $\alpha = .92$ for sexual fulfillment. Correlations between the subscales varied between $r = .31$ (vitality and physical contact) to $r = .65$ (physical contact and sexual fulfillment). For its use in Nigeria, the researcher carried out a pilot test using Cronbach's alpha method and coefficients of $\alpha = .68$ was reported.

Symptoms Distress Check List (SCL-90R)

This is a 90-item questionnaire developed and validated by Derogatis and Lipman (1977). It has subscales which one of them measure anxiety which was utilized to measure anxiety in the use of hormonal contraceptive in the current study. The researcher made use of 7-item subscale G measuring phobic anxiety from the 10 SCL subscales scale. The scale was validated in Nigeria for Nigerian population by Erinoso (1996) who established validity measures ranging from .49 to .76 across the subscales. The Anxiety subscale was pilot tested and the current study which ascertained that factor G measuring anxiety significantly loaded at alpha reliability of .60.

Procedure

Participants for the pilot test were 30 married women (those within childbearing age) who are attending clinical sessions (antenatal, gynecology session etc) at general hospitals in Anambra State. The sample for the pilot test shared homogeneous characteristics with the population of the main sample of the study. The essence of using a homogenous population during the pilot study is to avoid interference with the members of the main study in order to reduce test bias which comes from repeatability and familiarity with test instruments. By so doing, the researcher reduced bias rate to the responses and obtained true scores for validation and reliability purposes. Multi-stage sampling technique was used to select participants at various stages. For sampling the individual participants of the study; participants were approach at the antenatal units and were politely asked for their willingness to participate in the study. During the field work for data gathering, the researcher introduced herself as a student carrying out an academic inquiry and solicited for the help and cooperation of the participants. The researcher explained what the participants were expected to do with the questionnaire and provided instructions at the top of each questionnaire as well as practical assistance. The researcher together with the research assistance enjoyed the cooperation of the participants during the pilot study.

For the main study, the researchers sampled 209 married women (those within childbearing age) who are attending clinical sessions (antenatal, gynecology session etc) from Chukwuemeka University Teaching Hospital Amaku, Anambra State. Considering the challenge of sampling such a large population, the researcher employed the services of four National Youth Service Corps as Research Assistants for the field work. The Research Assistants were recruited from NYSC members serving in the state. The researcher provided training for the researcher assistants and ensured that they understand the study and can perform the administration of the test instruments during the field work without the assistance of the researcher since they were sampling the participants independently during the field work. The researcher also provided logistics needed for transportation, feeding and stipends for the recruited research assistants. For the sampling technique, the researcher utilized multi-stage sampling technique (purposive, cluster and simple random) to select ministries, departments, and agencies and participants sampled in the study. For sampling the individual participants of the study, participants' were

sampled in clusters where they were receiving antenatal sessions whereas simple random sampling was used to select each participant from the pool. While with the participants at the field work for data gathering, the researcher introduced himself as a student carrying out an academic inquiry and solicited the help and cooperation of the participants. The researcher explained what the participants are expected to do with the questionnaire and also provided instructions at the top of each questionnaire as well as practical assistance. The researcher and research assistants enjoyed the cooperation of the participants during the main study which hopefully lasted for 4 days. During the field work, 230 copies of questionnaires were administered, 221 (96%) were collected back and 209 (94.6%) were valid. The test administration showed high validity; thus, the valid ones were coded in an excel sheet and transferred to SPSS version 21.00 for analysis.

Design and Statistics

The research design for this study is factorial design (between subject design), this design can be utilized to ascertain the effect of marital support and body image on hormonal contraceptive use anxiety and whether there is an interaction effect between marital support and body image on hormonal contraceptive use anxiety. This design will be implemented using 2-way analysis of variance (2-Way ANOVA). All statistical analyses will be managed using SPSS analytical tool version 21.00.

Result

Table 1: Summary table of Mean and Standard deviation for the variables studied.

Dependent Variable: Anxiety				
MS	BI	Mean	Std. Deviation	N
High	Unhealthy BI	23.2687	2.55298	37
	Healthy BI	20.9706	5.21087	61
	Total High MS	22.1218	4.02274	98
Low	Unhealthy BI	25.1081	3.48939	40
	Healthy BI	20.7500	4.31906	71

	Total Low MS	22.9241	3.12559	111
Total	Unhealthy BI	24.5000	2.02661	77
	Healthy BI	20.8298	3.62557	132
	Total	22.7576	4.17627	209

MS = Marital support, BI = Body image

Data in Table 1 reveal that the initial result indicated that hormonal contraceptive anxiety among participants with high marital support was lower than those with low marital support at $M = 22.1$ (high marital support) and $M = 22.92$ (low marital support). Also, the descriptive statistics reveals that participants with health body image had less anxiety towards the use of hormonal contraceptive than their counterparts with unhealthy body image at $M = 20.8$ and $M = 24.5$ respectively. However, a test of between subject effects was conducted to ascertain whether the initial observed differences reached significant proportions.

Table 2: Summary table of 2-way ANOVA for the effect of marital support and body image on hormonal conceptive use anxiety

Source	Type II Sum				
	of Squares	df	Mean Square	F	Sig
Corrected Model	777.411a	3	259.137	11.169	.000
Intercept	192265.834	1	192265.834	8.287E	.000
Marital Support	642.407	1	642.407	3.562	.039
Body Image	503.286	1	503.286	4.776	.021
MS* Body Image	42.751	1	42.751	21.693	.000
Error	4500.952	205	23.201	1.843	
Total	217744.000	209			
Corrected Total	5278.364	208			

a.R Squared = .128 (Adjusted R Squared = .143)

The result in Table 2 shows that the initial group differences observed in hormonal contraceptive anxiety between participants with high marital support and those with low marital support was significant at $F = 3.6^*$, $p < .05$ ($N = 209$). Consequently, hypothesis one which stated that, women with high marital support will significantly differ on hormonal contraceptive use anxiety from women with low marital support. Hypothesis one is therefore confirmed. Also, the result reveals that women with healthy body image significantly had lower hormonal contraceptive use anxiety than their counterparts with unhealthy body image at $F = 4.8^*$, $p < .05$ ($N = 209$). Thus, hypothesis two which stated that married women with healthy body image will significantly differ on hormonal contraceptive use anxiety from married women with unhealthy body image in Anambra State was confirmed. Equally hypothesis three was confirmed whose findings reveal that an interaction effect between marital support and body image on hormonal contraceptive use anxiety at $F = 21.7^*$, $p < 0.05$ ($N = 209$).

Discussion

Evaluating the first hypothesis, finding revealed that significant mean differences in hormonal contraceptive use anxiety between married women with high marital support and those with low marital support. Data revealed that the hormonal contraceptive use anxiety among participants with high marital support was significantly lower than those with low marital support implying that participants who enjoyed spousal support had less apprehension and nervousness regarding the use of hormonal contraceptive. The finding implies that good communication, motivation and understanding from one's partner was found useful in reducing the associated nervousness, fear and apprehension regarding unknown consequences and outcomes of using hormonal contraceptive as method of family planning for effective spacing of children and population control. The finding is supported by Schwandt et al. (2021) findings from a study on the benefits of collaborative couple contraceptive use. Schwandt et al found that some men are opposed to use of male methods of contraception, and some are opposed to any contraceptive use, which leads to covert use with inherent anxiety about being caught and the unknown contraceptive

effects. Their study confirmed that women are most often burdened with seeking out information, initiating discussions, and sharing information discovered about contraceptive use with partners for the fear of not being supported by their partners. This fear is also transferred to the fear, nervousness and apprehension associated with such contraception use; but, when couple contraceptive use is collaborative, benefits range from marital harmony to husband's support of sustained use through reminders about appointments, joint counseling, and support in managing side effects.

Also, the finding is supported by Madugu et al. (2020) which evaluated the pattern of spousal support and communication among family planning clients in Nigeria and found that financial support from spouse encouraged greater number of wives in the use of contraceptives and this reduced anxiety associated with contraceptive use outcomes and side effects. Further support for the effect of marital support on hormonal contraceptive use anxiety was found in the study carried out by Challa et al. (2020) which evaluated the associations of spousal communication with contraceptive method use among adolescent wives and their husbands in Niger and found that that couples reports of spousal communication about contraception were positively associated with ever use of modern contraception and couples reports of spousal communication about contraception were negatively associated with covert modern contraceptive use compared to overt use. The authors also found that wives reports of spousal communication were marginally associated with covert use compared to no use but husbands' reports were not.

Evaluating the second hypothesis, findings revealed that participants with healthy body image had less anxiety towards the use of hormonal contraceptive than their counterparts with unhealthy body image. The finding associated differences in hormonal contraceptive use anxiety to the women body image perception which created anxiety towards hormonal contraceptive use anxiety. The initial differences in the groups (healthy body image group and unhealthy body image group) were equally confirmed significant in higher analysis. This means that wives are worried or nervous about body image distortions which could occur as a result of hormonal contraceptive use and this worry

and nervousness due to body image distortions caused significant anxiety across the groups.

The finding above is supported by Basha and Almeqrenb's (2020) study on anxiety and depression symptoms of married women using oral contraceptives which found that variables such as age, education, duration of marriage, duration of using medication and social perceptions and self-image affected contraceptive worries. This finding is similar to the current study because body image is likened to self-image and hence can provide an understanding regarding how perceptions of the self could affect hormonal contraceptive use anxiety as studied in the current study. The finding is also supported by Robaki's et al. (2019) study on hormonal contraceptives and mood which associated people perception of their looks and mood to contraceptive anxiety. Further support was found in Feder's et al. (2018) finding which highlighted that the impact of social factors such as the interaction of the self with the external environment the appreciation of self-perception and self-image in comorbidity following mental ill-health. The findings of this study are also supported by attribution (Abramson, 1989) theory which postulated that perceptions self, events and person's environment may motivate behavioural antecedents and dispositions.

Evaluating hypothesis three, interaction effect between marital support and body image was confirmed indicating that marital support and body image elevations significantly increased hormonal contraceptive use anxiety. As indicated in the group means, participants with low marital support and unhealthy body image experienced the highest hormonal contraceptive use anxiety than any other group whereas participants with high marital support and healthy body image experienced the lowest hormonal contraceptive use anxiety than any other members of the group. The finding is an indication of interaction effect indicating that hormonal contraceptive use anxiety experienced by the participants in interaction with the factors was affected depending upon participants' level of support and perception of body image. For example, this finding is supported by Awolude and Olatunji's (2019) findings that husband's financial support and approval for family planning use were negatively associated with covert contraceptive use among

women whereas Challans et al. (2020) finding which associated spousal support and communication directly boosts wives' self-esteem in seeking about contraceptive information.

Implications of the Study

There could be a number problem associated with hormonal contraceptive use anxiety the current confirmed that marital support and body image are part of factors which affect the hormonal contraceptive use anxiety. The study findings imply that the marital harmony is a strong factor which could influence women use of hormonal contraceptive. This is because only wives from harmonious marriage or home could enjoy spousal or marital support. Without marital harmony marital support may be difficult. The findings of the study further imply that wives perception of themselves could also affect hormonal contraceptive use anxiety. This is so because personal attributions as hinted by Abramson (1989) could either motivate or discourage behaviours including hormonal contraceptive use.

Limitation of the Study

Participants of the study were women attending antenatal care and clinical sessions at the public hospital. Although, the population is at the peak of child bearing considering their ages, the study did not filter out those who are in need of family planning. To reduce the possible effects of this, effort was made by the researcher to select majority of participants within 1-3 parity as they the critical group requiring family planning as against other groups.

Recommendation

In consideration of the theoretical model and findings of the study, effective sensitization and education is required at family and individual levels targeting wives and child bearing mothers to educate them on the benefits of harmonious relationship with self and spouse which can facilitate good choice of family planning methods. Prenatal and antenatal counseling is equally required to help mothers with unhealthy body image since it may affect their contraceptive use behaviour.

Suggestion for Further Studies

It is suggested that future studies on contraceptive use anxiety should compare other family planning methods with hormonal contraceptive to ascertain the variance in cost, ease of use, efficacy and unknown side effects. This will enable new grounds to be broken in understanding factors which influence participants' use of a particular family planning method and factors which trigger anxiety in the adoption of such family planning methods.

Conclusion

In this study, the researcher investigated the effects of marital support and body image on anxiety in the use of hormonal contraceptive. Using a factorial design, the study analyzed participants data and ascertained that both marital support and body image significantly affected hormonal contraceptive use anxiety. The study implicated harmonious marriage and self-perception attributions as proximal factors which can affect contraceptive behaviour among the sample. Recommendations were given as well as limitations of the study.

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