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Contraceptive Use Obstacles Faced by Newly Arrived Migrant Women

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ABSTRACT

Background: For recently arrived immigrant women, access to reproductive health care, including contraception, may be hampered by numerous obstacles. To eliminate these obstacles and advance access to care, community organizations', legislators, and nurses and other healthcare providers must collaborate. A current study was carried out to look at the Obstacles to family planning use among recently arrived immigrant women in Egypt. **Objectives:** This study assesses contraceptive use Obstacles faced by newly arrived migrant women. **Methods:** The current study used a descriptive exploratory research design to accomplish its goal. The study was conducted at the teaching hospital's obstetrics and gynaecology outpatient clinics in Egypt. A purposefully selected 500 migrant women. For data collection tools three instruments were used: a questionnaire for interviews, a tool to identify obstacles to contraception use, and a questionnaire to assess the complications of utilizing family planning techniques. Results: The current study assessed obstacles that women reported there are many obstacles to the use of contraceptives. Knowledge barriers, family barriers, transport barriers, institutional barriers and administrative barriers are only some of the obstacles that exist. Furthermore, the sociodemographic characteristics of the participants have a significant relationship with the existing obstacles. **Conclusion:** There are numerous barriers to the use of contraceptive methods, including inadequate awareness, a lack of techniques and medical supplies, and a lack of outpatient clinics that offer 24-hour services for all participants. **Recommendation:** By offering culturally appropriate education, language assistance, and patient guidance we can provide immigrant women with the knowledge and tools they require to make well-informed decisions regarding their reproductive health.

Keywords: Contraceptive Use; Migrant Women; Obstacles

INTRODUCTION

Many people around the world have been forcefully displaced due to war, political oppression, violence, and poverty (Chalmiers *et al*., 2022). In the latest Sudan crisis in April 2023, Egypt, a major neighbouring country, saw an influx of Sudanese citizens escaping the conflict. According to the United Nations High Commissioner for Migrants, over 317,000 migrants from Sudan arrived in Egypt (UNHCR, 2023).

Egypt has recently begun hosting migrants from neighbouring countries such as Syria, Jordan, Palestine, and Eritrea. As a result, health workers are now required to deal with diverse population groups, each with their own unique cultures, beliefs, and traditions regarding family planning (UNHCR, 2023). Family planning involves practices that help individuals and couples anticipate and achieve their desired number of children, as

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well as the spacing and timing of. Utilizing contraception can be lifesaving, empowering, and cost-effective for women life WHO, 2022. So, an individual's knowledge of contraceptive obstacles is very important that varies based on their unique understanding of a subject that gaining additional information about a contraceptive device and obstacles that also enhance and shape their existing knowledge (Wijaya *et al.*, 2022).

In its technical guidance for improving the health of migrant and migrant women and children, the World Health Organization emphasises that newly arrived women and those with uncertain legal immigration status face an increased risk of negative pregnancy outcomes (Chalmiers *et al*., 2022). In addition, migrants and migrant women, especially from low-income backgrounds, suffer from a higher burden of disease and worse health outcomes. These obstacles are linked to various pre-existing conditions, including the host country's socio-economic situation and lack of social support (Eshak *et al*., 2018).

Migrants often go through multiple traumas while seeking safety. As a result, they may find themselves in precarious situations, separating many children and families. This makes seeking reproductive health services a low priority. Additionally, access to contraception remains a challenge for migrant women due to various obstacles. Including language, low educational levels, lack of information, influence from family members, limited income, as well as cultural and religious norms (Sawadogo *et al*., 2023).

When immigrants seek refuge in other countries, there is a high demand for education, health services, infrastructure, natural resources, food, land, and security. Family planning (FP) interventions are given less priority. However, migrant populations face a variety of issues, including economic, sociocultural, and health-related obstacles, such as the ability to make decisions about contraceptive use in their new environment (Andrade, Sato & Hammad, 2021).

Contraception is a crucial need for migrant communities, but it is often limited and restricted by some host governments (Key *et al*., 2023). Contraception plays a significant role in improving the quality of life for migrant women, as the size of their families directly affects their well-being and support systems. Migrant women have encountered numerous obstacles in accessing contraception (Islam, Rahman & Khan, 2022).

New migrants to Egypt, particularly from Sudan, come from a country where only 2.7% of the population uses modern contraceptive methods. There is also a high unmet need for family planning at 30.8%, and the maternal mortality ratio is 789 per 100,000 live births (Triangulation of Migrants Stock in Egypt, 2022). Additionally, some migrants live in a society where men predominantly make decisions, including those regarding family size. Women who deviate from these expectations and use contraception may face serious repercussions, such as intimate partner violence, separation, or divorce (Kassim & Ndumbaro, 2022).

Several obstacles can lead to unintended pregnancies, including language obstacles, lack of information, peer influence, limited income, the desire to replace lost family members, side effects of contraceptives, socio-cultural preferences, and the unacceptability of contraceptive use (Achola *et al*., 2024). Nurses and midwives can make a significant contribution to enhancing newly arrived migrant women's access to and use of contraceptives by identifying and resolving these barriers, which will eventually improve their health and quality of life. So, the current study aims to explore the obstacles to contraceptive use among newly arrived migrant women in Egypt.

Significance of the Study

Unintended pregnancy is a major public health issue. As a result, enhancing services and quality, as well as the effective use of family planning methods, may lower the risks associated with unplanned pregnancy. Over 80% of migrants are women and children, who require lifesaving, empowering, and cost-effective measures, such as protection during humanitarian crises. Their lack of access to family planning services increases their risk of unwanted pregnancy.

In 2017, the global unmet need for family planning was 12%, with Africa having a higher rate of 22% (El-Moselhy *et al*., 2017). Since 1990, Egypt has been the Middle East's most populous country and Africa's third

most populous. However, Egypt did not meet the 2015 Millennium Development Goals, which called for a 70% contraceptive rate and a total fertility rate of 2.1 children per woman by 2017 (Bohl *et al.*, 2018). This problem is exacerbated by epidemics, which have resulted in inadequate or unavailable reproductive health care such as contraception and abortion services.

The issue is projected to worsen as Egypt's migrant population increases. With only six years left to achieve the sustainable development goals for maternal health and well-being, it is critical to identify barriers to the use of family planning services in order to plan effectively, overcome obstacles, and engage policymakers in addressing the need for and achieving the sustainability of reproductive health services (Aziz, & El-Gazzar, 2023; Darebo *et al*., 2024). Nurses play a critical role in assisting migrants with family planning services by providing information, counselling, contraception, and referrals. Nurses can help migrants improve their overall health and well-being by addressing sexual and reproductive health concerns.

Aim of the Study

The study aims to explore contraceptive use obstacles faced by newly arrived migrant women.

Research Questions

1. What are the obstacles faced by newly arrived migrant women when it comes to using contraceptives?

2. Is there a relationship between the obstacles of using contraceptives and socio-demographic characteristics?

METHEDOLOGY

For this study, descriptive exploratory research design was adopted.

Setting

The current study was conducted in the outpatient obstetrics and gynecology clinics of teaching hospitals in Egypt. These clinics provide free prenatal care, reproductive health services, and family planning methods. Arabs, Africans, and Asians, particularly Sudanese, made up a major proportion of the study group.

Subjects

A purposive sample of 500 newly arrived migrant women with inclusion criteria; as in their reproductive years, ages 18 to 49, regardless of parity, who use family planning techniques and are willing to participate in the study. The exclusion criteria: women who have mental problems or refuse to participate will be excluded.

Sample Size

The following statistical formula, $n = \frac{(Z^2\, p(1-p)}{d^2}$, was used to choose a total of 500 participants. In this equation:

n: Required sample size

Z: Z-score, which corresponds to the desired confidence level (1.96 for 95% confidence)

p: Estimated proportion of the population with the characteristic of interest (0.5 for 50%)

d: Margin of error (0.05 for ±5%)

Tools of Data Collection

Three tools were developed for data collection were utilized after reviewing the literature (Dwyer *et al.*, 2022; Kassim & Ndumbaro, 2022)

Tool (1): An Interviewing Questionnaire included three main parts as follows

First Part: Refuge women's demographic data, it consisted of 7 questions regarding age, education, country, income, occupation, and current residence.

Second Part: Obstetric characteristics included 5 questions about menarche age, gravidity, parity number, number of abortions, and complications from previous pregnancies and last labour.

Third Part: The family planning history involved 6 questions about the types of (FPM) used, how often they were used, reasons for choosing a specific method, duration of use, and sources of knowledge and the sources of availability. The Cronbach's alpha test was used to evaluate the tools' dependability, and the results showed that α=0.93.

Tool (2) Contraceptive Use Obstacles Questionnaire

It includes the challenges that women could encounter when utilizing FPM and has eleven items in total. As knowledge, family, place, transportation, and institution obstacles. Cronbach's alpha test was used to evaluate the tools' dependability; the result was α=0.89.

Tool (3) Family Planning Methods-Related Complications Questionnaire

It was divided into three sections: The first set of questions focused on the potential side effects of using FPM, such as headaches, impaired vision, nausea, vomiting, reduced sexual drive, and menstrual bleeding. The Second Nine questions about long-term FPM use consequences, such as hypertension, diabetes, anaemia, etc., The Third concentrated on determining the causes behind the FP methods' discontinuation and the feasibility of carrying out follow-up for FPM services. Cronbach's alpha test was used to evaluate the tools' dependability; the results showed that $\alpha = 0.88$.

Validity of the Tool

Three experts in community nursing and obstetric and maternity health nursing then evaluated the instruments' content validity. Changes were also made in response to the panel's comments regarding the content's appropriateness and clarity.

Pilot Study

Pilot research was conducted with 10% of the sample to ensure the clarity of the questions and make any necessary adjustments.

Data Collection Procedure

Researchers gathered data for three months, from February to April 2024. To gain the women's cooperation, they explained the goal of the study to each woman individually over 20–30-minute face-to-face interviews. They clarified how to use all of the data collection tools. And assisted those who were unable to read or write in answering the questions.

Statistical Analysis

The data was gathered, scored, tabulated, and analysed using SPSS version 23. All tables and graphs in this study using real data, percentages, mean, and standard deviation to present the findings. Relevant statistical tests were used, with a significance level of $p < 0.05$. These tests included the Kruskal Wallis & Mann-Whitney tests.

Ethical Consideration

The researchers obtained ethical clearance from Modern University for Technology and Information (MTI), Egypt-IRB with reference number IRB - FAN/138/2024 on 22nd January, 2024.

RESULTS

Table 1: Distribution of Participants According to their Socio-Demographic Characteristics (n=500)

Items	n=500	%
Age (years)		
> 25	118	23.6
25-35	258	51.6
≥ 35	124	24.8
(Mean ± SD)	**28.43 ±7.73**	
Level of Education		
Cannot Read and Write	42	8.4
Read and write	132	26.4
Secondary education	188	37.6
University education	138	27.6
Occupation		
Housewife	186	37.2
Working	314	62.8
Country		
Sudan	350	70.0
Syria	75	15.0
Jordan	25	5.0
Gulf Cooperation Council Countries	50	10.0

Table 1 shows the study included 500 migrant women with an average age of 28.43 years old (±7.73). Approximately 37.6% of the participants had completed a secondary degree. The majority of the sample (70%) were from Sudan, and 62.8% of them were employed.

Table 2: Distribution Among the Participants According to Obstetric History (n=500)

Items	n=500	%
Parity and Gravidity		
Primipara	72	14.4
Multipara	428	85.6
Type of Previous Delivery		
Normal Vaginal Delivery	318	63.6
Vaginal Delivery with Episiotomy	58	11.6
Caesarean Section	124	24.8
Previous Pregnancy Complications		
Yes	75	15.0
No	425	85.0

Table 2 demonstrates that multigravida women made up the majority of study participants (85.6%). 63.6% had delivered normal vaginally, and 11.6% had done having an episiotomy. Merely 15% had encountered difficulties in a prior pregnancy.

Table 3: The Prevalence of Current Contraceptive Method Use and the Sources of Availability (n=500)

Items	n=500	(%)
Contraceptive Method		
Hormonal	188	37.6
Intra Uterine Devices (IUDs)	232	46.4
Natural Contraceptives	42	8.4
Barriers Contraceptives	38	7.6
Sources of availability		
Public Hospitals	262	52.4
Privat Clinics	128	25.6
Pharmacies	110	22.0

Table 3 reveals that less than half of participants (46.4%) used IUDs, more than one-third (376.6%) used hormonal contraceptive, and the other participants utilized natural methods. Private clinics and pharmacies supplied the remaining family planning services, with government hospitals offering more than half (52.4%) of the total.

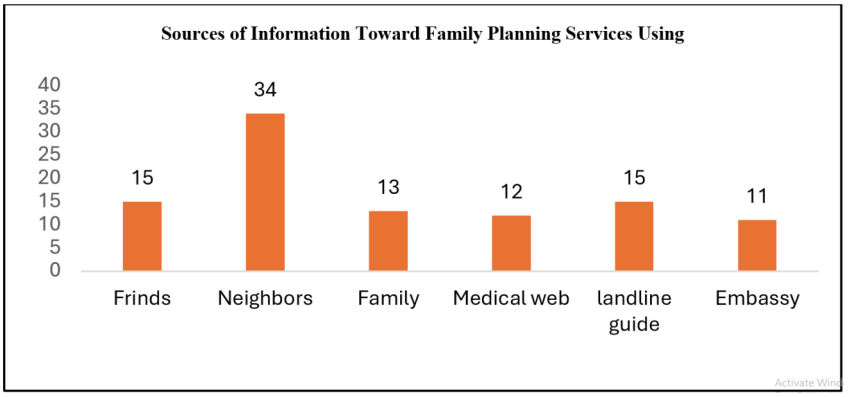

Figure 1: Sources of Information on Family Planning Services

Figure 1 illustrates that nearly one-third of the participants identified their neighbours as the main source of family planning information.

Table 4: Reasons for Selecting Family Planning Methods (n=500)

Items	n=500	(%)
*** Reasons for Selecting Family Planning Methods**		
Safe and efficient	500	100
Getting pregnant is easier after stopping	476	95.2
According to women's desire	480	96
Marital status should not be affected	456	91.2
Affordable and easily accessible	188	37.6
Don't affect breastfeeding	232	46.4
Previously used	394	78.8
Duration of Current Methods		
>1 year	110	22
2-3 years	172	34.4
3-5 years	164	32.8
<5years	54	10.8

** Not mutually exclusive*

Table 4 provides valuable insights into the reasons why participants choose family planning methods and how long they use them. All participants chose their methods based on safety and ease of getting pregnant after use. Additionally, nearly one third (32.8%) used the method for 3-5 years.

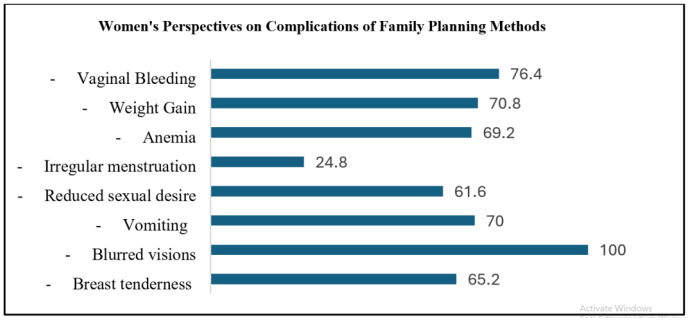

Figure 2: Women's Perspectives on Complications of Family Planning Methods

Figure 2 indicates problems such as decreased sexual desire (61.6%) and hazy vision (100%) weight gain (70.8%), haemorrhage (76.4%), and anaemia (69.2%) are among the side effects of prolonged use.

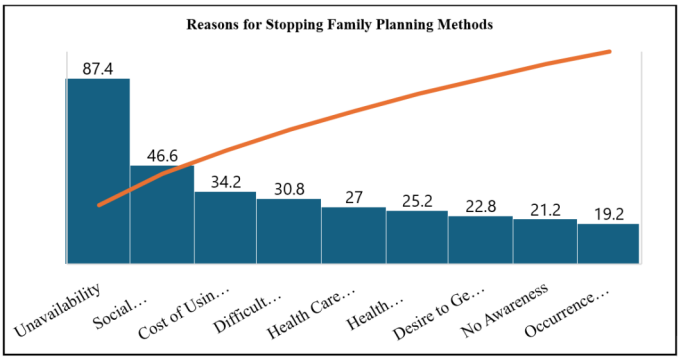

Figure 3: Reasons for Stopping Family Planning Methods

Figure 3 represents reason for discontinuation for FPM According to the study, 87.4 % of participants indicated that they might discontinue using family planning because they lack access to the same methods when migrating from their home countries. This factor is influenced by social and cultural disparities (46.6%), while the risk of complications was reported at the lowest percentage (19.2%).

Table 5: Obstacles Faced by Participants in Using Contraception (n=500)

Obstacles of Utilization	**n=500**	**(%)**
Knowledge		
Poor Information Regarding Using the Method	165	33.0
Family		
Husband's Desire for Children	112	22.4
Husband Complains About Methods	120	24.0
Family Income Not Adequate	181	36.2
Transportation		
Great Distance	90	18.0
Institutional		
Fear of Infection	337	67.4
Lack of Communication with Healthcare providers.	339	67.8
Lack of 24-hour service at the outpatient clinic.	500	100.0
Unavailability of FPM	247	49.4
Shortage of Medical Supplies	320	64.0
Administrative		
Official Paper Work and Registrations	410	82.0
Total Obstacles Mean of Utilization Contraceptive Method	**2.13 ± 0.27**	

Table 5 shows that approximately one-third of the participants (33%) lacked proper information about the method. In terms of family-related challenges, 36.2% of the participants cited inadequate family income. Related to transportation hurdles, 19% reported a distance between their residence and the hospital. Regarding institutional barriers, all participants mentioned a lack of 24-hour outpatient services, communication challenges with the healthcare team, concerns about infection, and shortage of medical supplies, at rates of 67.8%, 67.4%, and 64.0% respectively. Lastly, 89.2% of the participants encountered administrative obstacles, particularly in the registration process as foreigners.

Table 6: Relationship between Specific Sociodemographic Data and the Obstacles to Using Contraceptive Methods

Obstacles	Educational Level	Rank	Kruskal Wallis Test	*p*-value
Knowledge	Cannot Read and Write	158.98	4.46	0.05*
	Read and write	125.91		
	Secondary	118.95		
	University	111.89		
Family	Cannot Read and Write	115.64	0.80	0.02*
	Read and write	130.40		
	Secondary	129.25		
	University	123.96		
Institutional	Cannot Read and Write	130.50	1.13	0.01*
	Read and write	118.06		
	Secondary	131		
	University	124.85		
Transportation	Cannot Read and Write	144.38	4.68	0.19
	Read and write	107.24		
	Secondary	129.28		
	University	126.19		
Administrative	Cannot Read and Write	151.60	4.45	0.21
	Read and write	131.61		
	Secondary	122.77		
	University	120.11		

**Statistically significant*

Table 6 shows a significant relationship between knowledge obstacles, family obstacles, institutional obstacles, and the level of education ($p > 0.05$). Additionally, there was no statistically significant difference in transportation obstacles and administrative obstacles.

Table 7: Relationship Between Specific Sociodemographic Data and the Obstacles to Using Contraceptive Methods

Obstacles	Occupation	Rank	Mann-Whitney	*p*-value
Information	Housewife	115.85	6103.50	0.03*
	Working	111.21		
Family	Housewife	116.20	6234	0.01*
	Working	131.01		
Institutional	Housewife	119.89	6576.50	0.23
	Working	128.82		
Transportation	Housewife	114.29	6356	0.04*
	Working	132.14		
Administrative	Housewife	122	6773	0.53
	Working	127.57		

**Statistically significant*

Table 7 shows a significant relationship between knowledge obstacles, family obstacles, transportation, and occupation ($p > 0.05$). Additionally, there was no statistically significant difference in institutional obstacles and administrative obstacles.

DISCUSSION

The global phenomenon of migration continues to expand, leading to a significant number of women relocating to new countries for diverse purposes. Yet, the assimilation of migrant women into their host communities can pose considerable challenges, particularly in terms of accessing healthcare services. In Egypt, contraceptive usage is prevalent; however, migrant women may encounter distinct barriers when attempting to access these services. The study aimed to explore the obstacles of contraceptive use faced by newly arrived migrant women.

The current study comprised 500 migrant women who attended outpatient clinics, with an average age of 28.43 (±7.73). Moreover one-third of the participants had earned a secondary degree. The bulk of the sample was from Sudan, and approximately two-thirds were employed, implying that migrants in Egypt get assistance such as continual registration, access to various services, civil status, residency, and community-based protection operations.

This discovery supports the idea that the Arab Republic of Egypt serves as a migrant and asylum-seeking destination. Although Egypt does not have a land border with Syria, it continues to welcome Syrian migrants. Egypt is considered as a role model for social inclusivity, since it currently shelters about a million Sudanese and Syrian migrants who have access to public services such as education, healthcare, and other advantages equal to those enjoyed by local inhabitants (UNHCR, 2019).

The present study found that most participants were women who had been pregnant multiple times. Two-thirds of the total sample had previously had a normal vaginal delivery, while the rest had delivered vaginally with an episiotomy. A small number had experienced complications in a previous pregnancy. The researchers also investigated how the participants sought reproductive health services as their multiparity and their childbirth experiences.

Other studies have concluded that around two-thirds of Sudan's population has access to health care, despite the fact that only one-fourth of local health institutions provide the full range of basic/minimum health services. Access to care is influenced by individuals' health literacy, personal and societal values, living environment, and income, as well as the characteristics of healthcare providers such as availability, location, approachability, acceptability, and cost (Obels *et al*., 2022).

The study findings suggest that fewer than half of the participants used IUDs, more than one-third utilised hormonal methods, and the remainder used natural contraception. Furthermore, more than half of family planning services were available in government hospitals, with the remainder given by private clinics and pharmacies. This suggests that around two-thirds of individuals are at risk of having children due to a lack of hormonal family planning methods, changes in the methods used, and changing living conditions as a result of migration.

This finding is supported by Nabulsi *et al*., (2021), who studied barriers and facilitators of access to sexual and reproductive health services among migrant, internally displaced, asylum and migrant women: A scoping review they highlighted on Contraception is one of the needs of migrant communities with limited prioritisation and restrictions by some host governments on its access. The quality of life of migrant women can be improved through contraception, as family size has a direct impact on family well-being and support.

Nearly one-third of individuals named their neighbours as the primary source of family planning information. And they stated that they chose their procedures based on safety and the ease with which they could become pregnant following use. Furthermore, nearly a third of them followed their strategy for 3-5 years. According to Tanaka *et al*., (2024). Nepalese migrant women frequently ask their friends and family to bring contraceptives from their own country so that they can continue their practices. They also indicate that their information is likely to come from neighbours, friends, and relatives.

Regarding participants' perceptions of FPM problems that may affect their continued use of techniques, impaired vision was reported by all participants, as was diminished libido by more than half. Weight gain, bleeding, and anaemia were among the consequences of extended use reported by the majority of the migrants. Regarding the reason for quitting contraceptive use, more than 80% of participants stated that they may cease

using family planning because they did not have the same techniques when migrating from their place of origin.

In addition to social and cultural disparities of approximately fifty percent, the likelihood of complications was the lowest percentage of suspensions. The findings of the study were in linewith Gebrehiwot *et al*., (2024) in their study of barriers to contraceptive utilisation among reproductive-age women of Eritrean migrants in North Ethiopia, they stated that social disparities and complications from the used methods make women upset and discontinue the use of contraceptives.

As regards obstacles faced by the newly arrived migrant women in using family planning services, it showed that approximately one-third of the participants lacked proper information about the method. In terms of family-related challenges, the participants cited inadequate family income. When it comes to transportation hurdles, they reported a significant distance between their residence and the hospital acts as an obstacle to using FPM. The researcher found all these factors may interfere with the quality of reproductive health care in Egypt.

As mentioned by Ha *et al*., (2023) migrant women are confronted with unique challenges when it comes to accessing reproductive health services, such as contraceptives. Newly arrived migrant women may experience cultural and linguistic constraints, lack of knowledge of available services, and limited access to health care providers. These obstacles can increase the risk of unintended pregnancy, which can have serious consequences for both the individual and society. In addition to institutional hurdles, all participants cited a shortage of 24-hour outpatient services. Communication challenges with the health care team, such as linguistic clarification, some traditional ideas and accents from migrant women, were a major impediment, as were concerns about infection and, finally, a lack of medical supplies, and the majority of participants encountered administrative barriers, particularly during the registration process as foreign residents.

This study's findings are consistent with those of Peng & Ling, (2023) who found that migrant women may have difficulty accessing healthcare providers due to geographical barriers, a lack of transportation, or a scarcity of providers who speak their language. Furthermore, migrant women may face stigma and shame as a result of their immigration status, which can lead to feelings of embarrassment or shame about seeking reproductive health services, as well as fear of deportation or detention, which can be a significant barrier for migrant women seeking reproductive health services, including contraception.

As regards the relationship between family planning use obstacles and selected sociodemographic characteristics, the current study summarised the significant relationship between knowledge obstacles, family obstacles, institutional obstacles, and the participant's level of education ($p > 0.05$). Additionally, there is a significant relationship between knowledge obstacles, family obstacles, transportation, and occupation ($p > 0.05$). in contrast, there was no statistically significant difference in institutional obstacles and administrative obstacles with the participant's occupation.

CONCLUSION

There are numerous barriers to the use of contraceptives, according to the findings of the current study and research questions. Knowledge barriers, family barriers, transport barriers, institutional barriers and administrative barriers are only some of the obstacles that exist. Furthermore, the sociodemographic characteristics of the participants have a significant relationship with the existing obstacles.

Future research for this article could explore the impact of cultural sensitivity on participant willingness to disclose negative experiences by diversifying the sample further, incorporating different cultural, social, and demographic groups.

Recommendation

The current study suggested that community outreach programs can help in raising awareness of reproductive health services and enhance migrant women's access to care. Furthermore, governments should implement appropriate migration policies that enhance migrant women's access to healthcare services, including FP services.

Limitation

The sample size was increases to 500 participants was selected to address potential reluctance in

disclosing negative experiences, especially in culturally sensitive contexts. Future studies could explore strategies to enhance participant comfort and trust, enabling more clear sharing of experiences with deeper insights into sensitive issues.

Conflict of Interest

The authors state that they have no conflict of interest.

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