

An Exploratory Study of Factors Affecting Uptake of Family Planning Among Women of Reproductive Age in Ungogo Local Government Area of Kano State, Nigeria

Catherine C. Jerome*

*Nursing Services Department, Chief Nursing Officer, Texila American University, Zambia
Campus/National Orthopaedic Hospital, Dala Kano State, Nigeria*

Abstract

Introduction: The uptake of family planning services in developing countries has been found to avert unintended pregnancies, reduce maternal and child mortality. However, contraceptive prevalence rate still remains low. The objective of this study is to determine factors affecting uptake of family planning in Ungogo Local Government Area Kano State, from June to November 2023. Descriptive mixed-method was used to conduct cross-sectional study in Ungogo local government of Kano State. Ethical approval and informed consent were obtained. Systematic random sampling was employed to recruit 300 residents, aged 15-49 years. The interviewer administered questionnaire and in-depth interview guides were used to obtain information from respondents. Data was analyzed using SPSS version 21.0 and manually for quantitative and qualitative data respectively. Descriptive and inferential statistics were used and p-value less than 0.05 was considered statistically significant. The Socio demographic profile of respondents indicated that a good number of the respondents were between the ages of 15-24 (70%) and 25-34(30%). The study also showed that many of the respondents 40% (120) were married and of Muslim religion 240 (80%). The commonest family planning method used was implants (33%) followed by injectables (30%). Both the husbands and wives were jointly involved in family planning decision-making (96%). Maternal age, husband's occupation and prior treatment for infertility are factors influencing family planning decision – making. There is need to promote women's autonomy and control over their bodies and the need for men to be involved in maternal and child health programmes.

Keywords: Family Planning, Kano, Reproductive age, Women.

Introduction

The ability of women to take decisions in family planning issues such as family size, when to have a baby, choice of spacing period and the use of family planning services may not only enhance their bargaining power in family matters but will also reduce their vulnerability to sexually transmitted infections (STIs) [1]. Fertility and its decisions in the family are influenced by ideas and changes that occur in the life of the individual associated with such characteristics as education and income levels. Thus, as women

climb the educational ladder and men are faced with economic challenges of life, coupled with the pressure from the family to provide and satisfy their physiological needs, women are faced with the need to make choices in respect to the number of children they should give birth to and the size of their families and many others [2]. In developed and industrialized societies, the trend towards smaller family sizes has emerged due to the spread of formal education, medical and health advancements and the enhanced status of women. Education, for example, is a very

Received: 19.12.2024

Accepted: 10.02.2025

Published on: 29.04.2025

***Corresponding Author: kathejerome84@gmail.com**

powerful indicator of involvement in fertility decision making among women globally. It has been widely recognized as a key concept in understanding fertility behavior. Women who delay marriage are more likely to stay in school and then upon attaining higher education, are also more likely to find suitable employments, they are able to compete effectively with their male counterparts in family building and lower parities than their less educated female counterparts that give birth to larger number of children [3,4]. In as much as women have been empowered through education and economic employment to be assertive in family life decisions gender inequality, is a universal phenomenon which largely confronts women. The UN World Conference held in Mexico City, Copenhagen and Nairobi in 1975, 1980 and 1985, respectively for the advancement of women underscored the peculiar problems facing women. Globally women do not enjoy equality with men in terms of political, legal, social and economic rights. It has been observed that in every country, jobs that were predominantly done by women were the least well-paid and had the lowest status [5,6]. Ungogo L.G.A also has the highest rate of adolescent pregnancy (age 15–19) and the highest rate of pregnancy in very young adolescents, with 20% of adolescents becoming a mothers by age 16.

Factors Influencing Women's Family Planning Uptake in the Developing World

Human reproductive behaviour, which is the result of the complex interplay of numerous factors such as economic, social, cultural, religious and biological influences the reproductive decisions of women and their families in the developing world. These had led to high fertility rates in most developing nations and a rising Total Fertility Rate [5,6]

Economic Factors

In the developing nations, economic factors had been identified as the most dominant that influence women's child-bearing decisions especially in the rural communities. It has been found that fertility is higher among the low income groups. In their study of the fertility differentials in Latin America saw that there is a higher fertility rate among the destitute poor in Honduras and Bolivia respectively. With this poor socio-economic background, children from these poor households have less chance of acquiring an educational and nutritional profile that will secure them productive employment. With a higher level of marital instabilities in the region, most of these single mothers therefore enter the labor market at earlier ages. This shows that a number of Latin American and Caribbean countries, daughters of single mothers, have a higher probability of becoming pregnant teenagers [9].

Social Factors

Education, especially women's education, has received considerable attention from researchers and scholars concerning the concept of fertility in demographic literature. Writing on the situation in Bangladesh, the role education plays in women's childbearing decisions as influencing their supply of children, their ages at marriage, family size, duration of lactation and post-partum care, as well as education and welfare of their children, among others. In corroboration with Miller's view, postulated that the educated females are more conscious and courteous of their family size, quality of life and the functioning of their human bodies, placing a higher premium on their families' living standard, their health and the health of their children [2]. To Weeks, the educated women show a more positive attitude toward fertility regulation programmes than their illiterate counterparts. Age at marriage, which also influences the time of first birth is

another social factor that influences the reproductive decisions and fertility levels of women, which also determines the number of children they should give birth to during their reproductive years. Thus, many women in the rural communities of the developing world who marry at an early age, either consciously or unconsciously, have many children. Linked to these fertility decisions is the issue of residence, rural or urban which reveals that rural women in most cases have no role models, little or nothing to compete for and no struggle for the use of land, accommodation and other facilities as compared to their urban counterparts who have to compete for schools, health facilities, land, water, accommodation and other socio-economic facilities at higher cost [2,4].

Cultural Factors

The cultural traditions of people in most developing nations especially in Nigeria, play a major role in the reproductive decisions that couples make especially, women, close to 20 - 60% of the Nigerian men in his study said that they themselves are the sole decision makers in the area of child birth and family size. 40% to 50% of the female respondents also agreed that men do make the child birth decisions [4]. In patriarchal African societies, the fertility of women and men alike has long been highly valued with preference for large families, the care of children being the responsibility of all adults in the extended family, placing children in the care of others, marriage for women at young age and the polygamous marriage system [6]. The demand for children and large family sizes thus, become the sole goal for many patriarchal African societies. Another aspect of the cultural tradition that influences the child- birth decisions of women is the extended family system. [7] explained that the extended family has a great influence on the nuclear family members in the child- bearing decision making process, May also saw Family planning decisions to be more of a

group effort than we realised. This influence is so great among the Deltan communities where the survival of the patrilineage depends on its female members that a barren woman is seen as a disgrace and despair. The childless couple is scorned and despised, nicknaming the woman who fails to get pregnant as “Aga” (Infertile). In pre-modern Nigerian societies, women were seen as bearers of children and farmers. Within the traditional sphere, the childbearing ability of women was explained as the means by which the lineage ancestors were allowed to be reborn. Barrenness was therefore considered the greatest misfortune. It was confirmed that by this traditional view of procreation, about 60% of women in Nigeria’s rural communities preferred to have families of five (5) or more children [8]. Cultural beliefs in Nigeria detract women from their ability to negotiate sexual relations, determine the number of children they want to have and the method to apply in that regard, resulting in the high fertility levels in the rural corridors of the country. Children in the Nigerian cultural setting was seen as social insurance benefits of the aging parents, social prestige and source of labor in the agrarian societies where food and cash crop farming, fishing and animal rearing are the dominant economic activities. This makes the rural and uneducated women baby production machines, responding to the dictates of their spouses, friends and kinsmen so as to benefit from the tenth child reward [11]. Thus, [10] there is a strong traditional norm of high fertility as children are the “raison d’etre of marriage” which also results in higher fertility in the rural communities where sex preferences dominate their decisions, than the urban communities of the nation. The women’s place in the Family planning decision- making, her participation and concern are not the issue to be thought of by the spouse and his kinsmen. Most rural women still see themselves as toads under furrows that needed to be assisted to identify their potentialities so as to come out of the

socio- cultural doldrums they find themselves in with respect to child-bearing decisions: when to marry, when to give birth, how to space their births and the sizes of the family.

Religious Factors

Human reproduction, the Godly ordained process by which numbers were added to the human population through birth, had been with us from the Garden of Eden when the Supreme Being commissioned Adam to be fruitful and become many and fill the Earth. Gen.1: 26-28. The womb of the woman thus serves as the receptacle that carries the fetus, which through birth becomes the baby that adds to the human population every other day of the year. The emphasis placed on human reproduction is so great that in the Nepalese traditional/ Islamic religious societies, the birth of sons is seen as both social and economic advantages with the adage “May your progeny fill the hills and mountains” [12]. Conversely, religious beliefs and practices do prevent some persons from accepting or practising fertility regulation techniques as a means of making reproductive decisions. Thus, the concept of family planning and artificial contraception, reproductive health decisions and any form that follows the policies, tenets and decisions of the Programme of Action of the Cairo Conference [ICPD] 1994, were opposed by the Holy See, the Papacy of the Catholic Church [13].

Biological Factors

Marital relationships can be strained when children are not forthcoming, forgetting the scientific findings that the male could also be the cause. Writing under the caption, Gamete Source, Manipulation and Disposition, Tournaye reported that 51.2% of couples are infertile because of the male factor, with 39% of these men present with abnormal semen analysis for idiopathic reasons. The second largest category (23%) is men presenting with varicocele. The medical experts further stated

that within that major block of 51.2% is another 12% suffering from male accessory gland infections. To address this biological anomaly to satisfy the societal demand for children, couples who inherit these reproductive imbalances seek medical and scientific assistance in the forms of Artificial Insemination, Gamete Intra-Fallopian Transfer, Intra-cytoplasmic Sperm Injection, In vitro Fertilization and Zygote Intra-Fallopian Transfer to enable them mother / father children as their natural inalienable rights [14].

Women’s Participation in their Child-Bearing Decisions

Participation in child-birth decisions is one of the inalienable fundamental human rights of the individual. This is practiced based on the level of socio-economic and political autonomy that the individual possesses. In the Sub –Saharan African communities, the level of participation varies from urban to rural communities. In the urban African communities where the level of education is appreciably higher, access to education, information and other means of communication enables married couples to participate effectively in family planning and childbirth decisions of their families. Education was identified as the main source of women's autonomy, enabling them to gain control over their resources, make reproductive decisions, and expose themselves to the outside world and promoting husband-wife closeness [3]. It also encourages greater intimacy between spouses to enable them to discuss some culturally forbidden subjects as sexual behaviour, contraception and the number of children to give birth to. Thus, whether in the urban or rural communities, women with an appreciable or higher education tend to make positive reproductive decisions concerning when to marry, give birth, space or limit birth. This becomes more appropriate when both couples are better

educated. In the rural communities of most Nigeria communities where education is very low, women with no education tend to become “toads under furrows” that have to abide by the dictates of either their dominant male spouses or their patriarchal kinsmen or both in issues pertaining to their childbirth decisions. Women are seen as having very little or no role in their families' reproductive decisions and those women who indulge in strenuous work tend to have more children. They are seen to be on the supply side of the fertility divide, where preference is given to sons and their formal education to the disadvantage of daughters. Besides all the domestic chores on their shoulders, most rural women have to cope with pregnancies and continuous childbirths along with trading and farming activities. As the carriers and nurturers of the children of today and the future generation, the role played by women in the childbirth decisions should be given adequate support by society, whether rural or urban, to promote the development of society. There is a need to encourage their effective participation in childbearing decisions, considering their health needs.

Women's Perception as to what Constitutes an Ideal Family Size

The concept of an ideal family size is a measure of the desire among the members of a community as to the number of children a family should give birth to at a given time and a given context. It is a collective average of the number of children the family perceives to be what it can adequately cater for with the available resources at its disposal, according to the particular circumstances in which the household finds itself at any given time [9]. The concept of an ideal family size could be classified into four, namely, desired family size, preferred family size, expected family size and wanted family size.

The Desired Family Size

The desired family size refers to the response provided by any member of the community, especially the women concerning the number of children they want to have in all, including those that they already has. It was noted that family size preferences are represented by a combination of the desire for a total number of children and also by the desire for additional children. It is also simply the measure of the additional children [12]. The concept of the desired family size as one gets married or has just got married may vary with time, taking into consideration the issue of child survival, family and cultural background and the status of the couple concerned.

The Preferred Family Size

The family size preferences can take various forms. Within the context of a particular family, parents may desire at least one child of each sex, or approximately an equal number of particular sons and daughters. Yet some couples may continue to bear children beyond their desired family size in order to achieve a favourable distribution of sons and daughters. The preferred family size was seen as the number of children respondents would like to have in the absence of any constraining factors, including unfavourable demographic or child-bearing experiences or socio-economic conditions and circumstances [12].

The Expected Family Size

This concept, which has gained much acceptance in developed societies, is normally derived from interviews with couples about the number of children they prefer. Some couples who might have fertility impairments and accordingly will have fewer children than they would prefer, may expect to have still more [15]. These groups of individuals might be having two (2) children at the moment but may wish or expect to have an additional two

(2) or more based on their child sex preferences which they have not been able to satisfy.

The Wanted Family Size

In trying to differentiate between the concept of Desired and the Wanted Family Size based on an individual's single and successive decision-making perspective [12]. Considering an individual's single-decision perspective, family preferences are often represented by the desire for a total number of children. However, from the successive decisions perspective, they are represented by the additional children. One school of thought believes that family size preferences are fixed at the time of marriage and retained as a goal throughout the fertility career. Another school of thought, however, argues that the actual child-bearing experiences, coupled with other varying circumstances, will lead to a continuous revision of the family size preferences, either to limit birth or add to the number of children the couple have, as the woman advances in her fertility career. The ideal family concept therefore, helps in shaping the fertility of the society. It also helps in initiating family planning programmes that target individuals who will wish to freely implement their preferences by achieving their desired family size goals so as to avoid unwanted pregnancies.

Methods

The method for the study under the following headings: the research design for the study, area of study, study population, sample size, sampling procedure, instrument for data collection, validity and reliability of the instrument, ethical consideration and procedure for data collection and method of data analysis [16].

Research Design

The design used for this study was a mixed-method cross-sectional research using both qualitative and quantitative designs, which

involves measuring the outcome and the exposures in the study. The research design was considered appropriate as the researcher is concerned with the Assessment of Family planning decisions of women in Ungogo Local Government Area, Kano State. It involved orderly collection of data, analysis, interpretation and reporting of pertinent information about the current situation [17].

Area of Study

The study was conducted in Ungogo Local Government Area of Kano State. Kano is a state in Nigeria. It is located in the northern part of the country, lying between latitudes 12°05'26"N and 8°29'48"E. The state is located in the North West geopolitical zone. Kano is one of Nigeria's 36 states. It has an area of 204km² and a population of over 369,657 people at the 2016 census. The state was created in 27th may 1967. Ungogo is a Nigerian local government area located within Kano State and sharing boundaries with some other Local Government Areas. The people of Ungogo are of the Hausa ethnic extraction. Ungogo local government area is situated in Kano state, North-west region of Nigeria. The LGA has its headquarters in the town of Ungogo and is made up of 57 numbers of towns and villages which include Adaraye, Bagujan, Dankunkuru, Indabo, Karo, Kwajalawa, Wujanare, Zikaya, and Yanmata. Etc. The estimated population of Ungogo LGA is put at 249,058 inhabitants, with the vast majority of the area's populace made up of members of the Hausa/Fulani ethnic subdivision. The Hausa language is commonly spoken in the LGA, while the religion of Islam is extensively practiced in the area. Notable landmarks in Ungogo LGA include the Dausara Primary Health Care Centre.

Geography of Ungogo

Ungogo LGA sits on a total area of 204 square kilometers and has an average temperature of 33 degrees centigrade. The

LGA witnesses two major seasons which are the dry and the rainy seasons with average humidity levels in the area put at 28 percent.

Economy of Ungogo

Ungogo LGA has a rich agricultural heritage with crops such as rice, sorghum, soybeans, and groundnut grown in the area. Trade also blossoms in Ungogo LGA, with the area hosting several markets such as the Bachirawa market, which attracts hundreds of buyers and sellers of diverse commodities. Other economic activities in Ungogo LGA include hunting, pottery, and animal rearing. Ungogo has a male population of 192,372 and a female population of 173,365 for a total of 369,657 according to the 2006 National Census [18].

Population for the Study

The target population consists of the women of family planning age (15 to 49) years in Ungogo Local Government Area who are residents of the communities that constitute the Local Government Area. The total projected population of females in the Ungogo Local Government Area is 173,365 in 43. The population of females from the six selected communities is 10,000, and 22% amount to 2000 according to 41 i.e. women of Family planning age [18, 19].

Sample for the Study

The sample for the study was determined using power analysis. The formula for calculating sample size by 42 is as follows: $N = Z^2 P (1-P)/d^2$ in 42. Where the minimum sample size required, $Z=1.96$ at 95% confidence interval, P =proportion or a best guess about the value of the proportion of interest. In this study, there is no information on the proportion of interest in family planning decisions of women. Therefore, the 50% usually used for unknown proportion is used. It is expressed in decimal that is 0.5, d = error margin i.e. 0.05 Applying this formula, a

sample of 300 women was selected and a 10% attrition rate brought the sample size to 287.

Sampling Procedure

This involved a multi-stage sampling procedure. Ungogo Local Government Area was selected for the study based on the researcher's knowledge about the population. In the first stage, the 17 communities that constitute Ungogo L.G.A were listed. Simple random sampling with replacement was used to select six communities which represent approximately 40% of the entire women's population. Six communities were selected because the population for the study is widely dispersed. This was also to enable the researcher to manage available resources and time. In the second stage, a stratified sampling method was used to select women of family planning age, and because the population of women from each community was known, a proportional stratified sampling method was used to select the representative sample size. In the quarters (Ogbe's), the population was also known therefore, the researcher also used a proportionate sampling design to select a representative sample of Family planning women from each quarter using the following formula: $NS = N_s \times n/N$. Where NS = sample size from the community, N =population size of the community, n =sample size for the study, N =total population Instrument for Data Collection. Data was collected using interviewer interviewer-administered questionnaire constructed by the researcher according to the objectives of the study on assessment of Family planning decisions of women. The researcher designed a closed-ended and open-ended structured questionnaire (Appendix A). The questionnaire has 4 parts: participants' demographic characteristics, pattern of childbearing among women, factors influencing family planning decision among women in Ungogo Local Government Area and extent of women's participation in

childbearing decision. Validity of Instrument: Face and content validation of the instrument was done by the project supervisor. His inputs were used to modify the instrument for a pilot test. The researcher-designed tool was also sent to various experts for their expert opinion and construct validation. The experts include; maternal and child health educator, family planning specialist and expert in the field of measurement and evaluation. The validators critiqued the items of the questionnaire regarding clarity, suitability, scope, validity of constructs and coverage of study variables in line with the topic and objectives. Items not found to be valid were either eliminated or modified to agree with the validators observations. Reliability of Instrument To establish reliability of the instrument, a pilot test was conducted using thirty women of Family planning age in Ungogo Local Government Area, who all share similar characteristics with the actual population of the study. The data generated was tested for reliability using spilt half reliability technique. The Pearson Product Moment Correlation formula was applied to obtain the reliability coefficient. A reliability coefficient of $r = 0.97$ was obtained. The instrument was considered reliable for the study.

Procedure for Data Collection

The researcher trained four trained nurses as assistants to administer the questionnaire. The research assistants who understood the local language were trained to understand the objectives of the study and how to administer the instrument to the respondents. They were instructed to understand the project being carried out. The letter of introduction, the

authority letter and ethical clearance were made available to the research assistants. These documents were presented to the respondents to gain their acceptance and co-operation. The researcher reached the eligible women by visiting them house by house in each quarter based on the required number from each village. Upon signing the informed consent, the questions in the questionnaire were administered to the respondents who met the inclusion criteria and those that could not read the English version had the questions interpreted in Hausa language to the selected respondents and their responses were recorded into the questionnaire. Data collection was done from 9am to 11am each day excluding Sundays. A total of five (5) weeks was used for data collection. Each selected and consenting respondent had only one opportunity to participate in the study. This one opportunity was controlled by a form of identification on the certificate of informed consent. Completed questionnaires were collected the same day. Data were collected until the sample size from each quarter attained. Method of Data Analysis Quantitative data were collected and analyzed using IBM/SPSS version 20. Results were presented in tabular form. Each of the facets of the responses in sections A and B of the instrument was presented in their respective categories as tables, including frequencies & percentages. Ethical Consideration and Ethical approval were obtained from the Kano State Ministry of Health. Informed consent was obtained from the respondents. Privacy and confidentiality were ensured.

Results

Table 1. A Demographic Profile of Family Planning Women in Ungogo Local Government Area Kano.

n=300

Locality	Frequency	Percentage
Adaraye	50	16.66
Bagujan	50	16.66
Dankunkuru	50	16.66

Fanisau	50	16.66
Indabo	50	16.66
Karo	20	6.66
Grand Total	270	
Age at First Pregnancy		
15-19	20	6.66
20-24	25	8.33
25-29	11	3.66
30-34	1	0.33
35-39	0	-
40-44	0	-
45-49	0	-
Marital Status		
Married	120	40
Not married	30	10
Widow	60	20
Cohabiting	30	10
Divorced	60	20
Respondents Occupation		
Farmer	2	0.66
Full housewife	178	59.33
Petty trader	71	23.66
Public servant	18	6
Others	1	0.33
Respondents Religion		
Christianity	30	10%
Islam	240	80%
Traditional	30	10%
Others	0	0%
Husband's Occupation		
Farmer	150	50
Petty trader	25	8.33
Businessman	35	11.66
Public servant	60	20
Respondent Educational status		
No formal education	7	2.33
Primary education	3	1
Qur'anic school	25	8.33
Secondary education	138	46
Husband's Wealth Quartile		
Rich	42	14
Moderate	48	16
Poor	210	70

Co-wife Quartile		
1	132	44
2	117	39
3	36	12
4	15	5

Sociodemographic characteristic (N=300)

Table 1: The socio-demographic profile of respondents indicated that a good number of the respondents were between the ages of 15-24 (70%) and 25-34(30%). The table also revealed that many of the respondents, 40% (120), were married and of the Muslim religion, 240 (80%). About 178 respondents (50%) and 138(40%) for men and women, respectively, had formal education, while 10% had primary education. It was also observed that many respondent, 178(61%), are full housewives and 71(13%) or 18(4%) are petty trader or public servants as their major economic activities. A few respondents were, however, either farmer or others. The husband's wealth quartile which indicates that 70% of them are poor, 16% are living moderate and 14% are rich. The table also discloses that respondents husband married 1 wife (44%) some 2 wives (39%), 3 and 4 respectively as (12%) and (5%).

Hence, this finding was not in conformity with assertion made by [2] who saw fertility and its decisions in the family to be influenced by ideas and changes that occur in the life of the individual associated with such characteristic as education and income levels. Thus, as women climb the educational ladder and men are faced with economic challenges of life, coupled with pressure from family to provide and satisfy their physiological needs, women are faced with the need to make choices with respect to the number of children they should give birth and size of families [2]. The findings was also contrary to the assertion made by [3] who noted that; In the developed and industrialized societies, the trend towards smaller family sizes has emerged due to the spread of formal education for women and the

enhanced economic status of women [3]. Education, for example, is a very powerful indicator of involvement in fertility decision making among women globally [9]. It has been widely recognized as a key concept in understanding fertility behavior [3]. This shows that women who were not enlightened educationally as well as on their rights are not likely to be knowledgeable about their child-bearing decisions and will not show positive attitude to fertility regulation programmes. Generally, the occupation/economic activities conformed with the general employment trend where women are mostly found in the informal sector. The higher concentration of respondents in the informal sector is attributed to the few respondents with higher education which is a requirement for recruitment into the formal sector. This explanation is in line with [21], submission that female access to education would expose them to better-paid jobs. Here, Momsen has established the relationship between education and employment. Education and employment also influence Family planning decision. When women are exposed to opportunities of education and employment, time" becomes an important factor in household decision on number of children to bear. With a higher percentage of women in employment, it is expected that they would be exposed to the stress of the double burden of childrearing and productive roles and their leisure would become valuable [21]. The effect would be women's preference for fewer children. It is contended that as the wealth of women increases through their engagement in economic activities with children no longer used as source of wealth, the opportunity cost

of raising children becomes higher and the incentive to have children declines.

Table 2. Objective One: To determine the Pattern of Family Planning Among Women in Ungogo LGA

No. of children	
0-2	16%
3-5	49%
>5	34%
Grand Total	100%
Have you Previously Used Any method of Family Planning	
Yes	140 (46.67%)
No	160 (53.33%)

Count of What Type of Method Do You Use?	Frequency	Percentage
Condom	15	5
Implant	99	33
Injectables	90	30
Loop IUCD	3	1
Natural Method (Withdrawal Or Cycle Bead)	18	6
Pills	75	25
Reasons For not Using Any Method		
Discouragement from friends	12	4
Lack of fund	9	3
Not Readily Available	9	3
Refusal by spouse/family	213	71
Side effect	57	19
Who do you think take decision of family planning?		
Both husband and wife	288	96
Husband	9	3
Wife	3	1
What to do to improve the use family planning by women	YES	NO
Providing contraceptive and guidelines	158	20
Reproductive Health Surveys	90	10
Assessing your program's contraceptive supply needs	22	5

The result in the table shows that many (221) of the women had between 1-5 children. They represent 65%, this was followed by those who have had between 5-10 children. They were 34, and the number represents 30% of the respondents. The mean value is 4.68. Age at first birth and it showed that the average woman starts sexual debut at 15 years old, hence the mean value is 16.18, and the age with the highest frequency is 15-19 years. Most importantly, the total number of 140

women have previously used family planning, which is 46.67% of the respondents, and 160 (53.33%) have not.

Furthermore, Implant is the most used type of family planning by 99 women (33%), then followed by Injectable used by 90 women (30%), and Pills used by 75 women (25%) and others. The table also discloses the reasons why some women refused to use the family planning method, of which Refusal by spouse/family is 213 (71%) of the women,

while 19% was due to the side effects. To improve the use of family planning adopted mostly by the 158 (60%) women were provided contraceptives and the guidelines, and 90 women adopted the use of Reproductive health surveys, while 22 women agreed on assessing their program for contraceptives supply needs. Finally, the decision of family planning was mostly agreed upon by both the husband and wife, with 96% taking.

NB: Tables 1 and 2 were cited by Catherine C. Jerome (MPH), Texila American University, Zambia Campus, 2024.

Discussions

Education and enhanced economic power of women have been seen as a prerequisite to effective decision making of all kinds, including that about the Family planning decision among women's in line with Momsen, (2020) submission that female access to education would expose them to better-paid jobs. Here, Momsen has established the relationship between education and employment. Education and employment also influence Family planning decisions. When women are exposed to opportunities for education and employment, "time" becomes an important factor in household decisions on several children to bear (Momsen, 2020).

Conclusion

The empowerment and autonomy of women to enable them to take active part in their childbearing decisions, decide as to when to marry and give birth, and either to space or

limit their births have been given much prominence at major international and national seminars and conferences on population, women and Development over the years. Particular reference could be made to the Programme of Action at the ICPD of Cairo, 1994 (UN, 1995), and the World Conference on Women in Beijing, China in 1995 (UN, 1996), where governments were expected to apply all the protocols signed and principles and policies agreed upon to the letter. These notwithstanding, many women in rural communities of most countries in the developing world especially in sub-Sahara Africa (SSA) face the same problems that were discussed in the international circles such as poverty, male dominance, marital instability, high birth rate, ineffective participation in their childbearing decisions, pregnancy and birth complications among others, and their effects on the women and their children. The study also revealed that women of the study communities do not independently make decisions in their Family planning issues, and most women are not educated; hence, education is a prerequisite for effective reasoning and informed decision making.

Conflict of Interest

The author declares that there's no conflict of interest.

Acknowledgement

I wish to express my gratitude to all who have contributed to the reality of this work.

References:

[1]. Tavory & Swidler, 2009, Women's role in reproductive health decision-making and vulnerability to STD and HIV/AIDS in Ekiti, Nigeria: Paper presented at the SARE/SIDA workshop on Indian and collective vulnerability to STD/HIV in Africa held at the University of Ghana, Legon, Accra.

[2]. Weeks, A., 2007, Maternal Mortality: It's Time to get Political. *BJOG*; .94(1), 74-93 *Westoff, C and World Health Organization*. 2022, Current Practices and Controversies in Reproduction
[3]. Miller, A., 2010, Mothers' Education and "Childhood Mortality: *Health Policy*. 64(3), 15.
[4]. United Nation 2003, Population and Development: Programme of Action Adopted at

the International Conference on Population and Development, Cairo. September 1994, *New York, and U.N. Population Division*.

[5]. Pietila, H., 2007, *The Unfinished Story of Women and the United Nations*: New York, Geneva, United Nations. 120-126, <https://digitallibrary.un.org/record/592517>

[6]. Marger, M. H., 2008, *Social Inequality. Patterns and Processes*. Mountain View, California, London. Toronto. *Mayfield Publishing* .41(4),528-549

[7]. L., Bernardi, 2014, Social network and fertility; *Demographic research*. 30(22), 641-670, <https://www.demographic-research.org/articles/volume/30/22>

[8]. Avatim, W. \$., Weeks, J., 2010, Challenging Unequal Gender- Based Power Relation in Sexual and Reproductive Health: A Case Study of SEND Ghana's Eastern Corridor Livelihood Security Promotion Programme, Graduate school of Development Studies, *The Netherlands: The Hague: International Institute of Social Studies*. 623-626, Erasmus University Thesis Repository: Challenging Unequal Gender-Based Power Relations in Sexual and Reproductive Health: A Case Study of SEND Ghana's Eastern Corridor Livelihood Security Promotion Program (ECLSPP)

[9]. U.N., 2009, *Population Bulletin of the United Nations: Prospects for Fertility Decline in High Fertility Countries*, New York. U.S.A: U.N. Population Division. 46(42), 16, <https://www.un.org/development/desa/pd/content/population-bulletin-united-nations-prospects-fertility-decline-high-fertility-countries>

[10]. Oppong, C., & Abu, F., 2007, *Sex Roles, Population and Development in West Africa: Policy Related Studies on Work and Demographic Issues* 7thEdition, Portsmouth, Heinemann Educational Books Inc https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undp_egm_200107_background_paper.pdf

[11]. Bleek in Stephenson, 2006, *Children in the Nigerian cultural setting as social Insurance: Cultural reasons of childbearing*. 2(3), 18.

[12]. Billari, F., Philipov, D., & Testa, M. R., 2009, Attitudes, norms and perceived behavioural control: Explaining fertility intentions in Bulgaria. *European Journal of Population*, 25(4), 439-465.

[13]. McIntosh, C. A., & Finkle, J. L., 2005, The Cairo Conference on Population and Development: A New Paradigm, *Population and Development Review* 21(2), 224.

[14]. Freyka, T., 2017, Religiousness and fertility – population and development. 33(4), 785-809.

[15]. Cadwell, J.C. 2009. Education as a Factor in Mortality Decline: An Examination of Nigeria Data in *Population Studies (Women)* 3(21).

[16]. Creative Research System 2012, Formular for calculating sample size: Retrieved January 8,2013 from www.surveysystem.com/sample-size-formular.htm.

[17]. Chandrashekara, S., 2012, Sample size estimation and power analysis for clinical research studies. *Journal of human reproductive sciences* 5(1), 7-13.

[18]. National Population Commission (NPC), 2014, [Nigeria] and ICF Macro, *Nigeria Demographic and Health Survey 2013*. (Abuja: National Population Commission and ICF Macro, 2014), p. 8, <http://www.measuredhs.com/pubs/pdf/SR173/SR173.pdf>

[19]. National Population Commission 2014, *Housing and Population census, 2006*. Abuja, Nigeria; Federal Government Printer.

[20]. National institute of health (.gov) <https://www.ncbi.nlm.gov/pmc>. Y.D Guracho.2022

[21]. Momsen, J. H., 2004, *Gender and Development*. London & New York Routledge <https://www.scirp.org/reference/referencespapers?referenceid=1958142>